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SECRETARY OF THE AIR FORCE

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Health Services

MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM (MEPRS) FOR FIXED MILITARY MEDICAL AND DENTAL TREATMENT FACILITIES

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This publication implements Air Force Policy Directive (AFPD) 41-1, *Health Care Programs and Resources*, and Department of Defense (DoD) 6010.13-M, *Medical Expense and Performance Reporting System (MEPRS) for Fixed Military Medical and Dental Treatment Facilities Manual.* It mandates use of the Medical Expense and Reporting System (MEPRS) in Air Force Medical Treatment Facilities (MTFs). It does not apply to Limited Scope Medical Treatment Facilities (LSMTFs) medical aid stations, squadron medical elements, designated functional flights, deployed mobile MTFs, occupational and environmental health laboratories, medical research and development functions, Air National Guard Medical Units, or Air Reserve Medical Units. This publication may be supplemented at any level, but all direct Supplements must be routed to the OPR of this publication for coordination prior to certification and approval, also send any comments or suggested improvements on AF Form 847, *Recommendation for Change of Publication*. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) located at **https://www.my.af.mil/gcss-af61a/afrims/afrims**/

SUMMARY OF CHANGES

This AFI has been reformatted, and includes revisions for the updates in Expense Assignment System Version IV *internet* (EASIV*i*). This reflects a change in AF reporting guidance by using Defense Medical Human Resource System *internet* (DMHRS*i*) for time and salary reporting. This also includes guidance excluding Limited Scope MTFs from reporting MEPRS data.

Section A—Overview

1. Major Functions and Responsibilities:

1.1. **The Assistant Secretary of the Air Force for Manpower and Reserve Affairs (SAF/MR)** serves as an agent of the Secretary and provides guidance, direction, and oversight for all matters pertaining to the formulation, review, and execution of plans, policies, programs, and budgets.

1.2. **The Surgeon General, (AF/SG) will:**

1.2.1. Implement Medical Expense & Performance Reporting System (MEPRS) for Fixed Medical and Dental Treatment Facilities IAW DoD 6010.13-M.

1.2.2. Develop guidance for uniform reporting requirements and comparable data submission to designated management levels within DoD.

1.3. **Air Force Medical Support Agency (AFMSA)/SG8YR will**:

1.3.1. Arrange for funding of Air Force MEPRS software and hardware requirements.

1.3.2. Participate in and direct release of MEPRS software.

1.3.3. Act as Air Force representative to the Tri-Service MEPRS Management Improvement Group (MMIG) to make Tri-Service guidance regarding MEPRS and EASIV systems.

1.3.4. Direct guidance updates/changes for Air Force specific requirements.

1.4. **The Command Surgeons will** ensure facilities provide timely and accurate MEPRS reports.

1.5. **Air Force Operations Agency (AFMOA)/SGAR will:**

1.5.1. Aid MAJCOM SGs and MTFs in providing timely and accurate data transmissions.

1.5.2. Act as focal point between MTFs and AFMSA/SG8YR on MEPRS related issues.

1.6. **The Air Force Program Executive Office Enterprise Information Systems (AFPEO EIS/HIB) will:**

1.6.1. Test software; provide instructions and guidance for implementing system changes.

1.6.2. Provide field assistance to all Air Force MTFs for EAS related software problems.

1.6.3. Act as Air Force authorizing agency for EAS and central repository access.

1.6.4. Act as interface with the TRICARE Management Activity (TMA) and Defense Health Service Systems (DHSS) to resolve all AF unique infrastructure issues, assist with the definition of system requirements, test and support the implementation of all software upgrades.

1.7. **Medical Wing/Group Commander will:**

1.7.1. Assume responsibility for overall operation of MEPRS within the MTF.

1.7.2. Integrate MEPRS information into the MTF's management audit and review structure.

1.8. **The Medical Resource Management Function will:**

1.8.1. Manage MEPRS program within the MTF.

1.8.2. Ensure MEPRS data is accurate and timely as a participant in the MTF Data Quality Management Control Program (DQMCP).

1.8.3. Perform MEPRS data analysis and ensure ongoing feedback on performance measures to the Cost Center Manager Program and Executive Committee.

1.9. **The MEPRS Program Manager (MPM) will:**

1.9.1. Be responsible for the analysis and overall timely submission of validated MEPRS data by 45 calendar days after the end of the reporting month.

1.9.2. Provide mandatory training at least once a year for the MEPRS work centers Point of Contact (POC) with recurring training as necessary.

1.9.3. Coordinate with the Budget Analyst, Logistics, Manpower, Facility Management, specific work centers, and any other personnel necessary to ensure at least annually, that the methodology for reporting workload is accurate.

1.9.4. Be responsible for gathering and validating manually input data, in a timely manner.

1.9.5. Ensure the 100 percent of timecards have been approved before generating the DMHRS*i* output file. The labor hours and salary are a critical data component depicting the AFMS level of effort, by which we are reimbursed for healthcare activities.

1.9.6. Complete reconciliation of financial, personnel and workload data in coordination with the appropriate personnel.

1.9.7. Review all data sets, annually and as needed. There is more specific guidance on the responsibilities of the MPM in the following sections.

1.10. **Flight Commanders will**:

1.10.1. Ensure a MEPRS work center POC and alternate are appointed in writing to act as a liaison with the MPM.

NOTE: It is highly recommended that the MEPRS work center POC(s) be military (an E-5 or above) or civilian (GS/WG-06 or above). These tasks could potentially be performed by one or more persons, if multiple POCs are used, identify them separately on the appointment letter with responsible task (DMHRS*i*, workload or financial).

1.10.2. Validate and approve all work center data collection processes for their Flights/Elements when required, but at least annually.

1.11. **The MEPRS Work Center POC or Alternate will**:

1.11.1. Coordinate all work center specific issues concerning MEPRS, which includes workload, expenses and personnel time reporting. They will forward all required workload reports to the MPM within 3 workdays after the end of the reporting month. When an electronic submission is used, a local process must be implemented to notify the

MPM that the data has been validated and submitted. The work center POC will ensure the accuracy of the workload for the productivity of their work center and the timely submission of the workload to the MPM.

1.11.1.1. In conjunction with the MPM, ensure accurate Functional Cost Codes (FCCs) are used and provides work center specific training as needed.

1.11.1.2. Be responsible for ensuring all personnel (assigned, borrowed, contracted or volunteer) within their work center completes their biweekly timesheet in DMHRS*i*. They must notify the DMHRS*i* Human Resource (HR) Manager and the MPM of all departures, arrivals, transfers, changes in demographic information and other pertinent data.

1.11.1.3. Approve or reject timecards NLT COB the third duty day after timecard period ends (Wednesday). All rejected timecards must be corrected, re-submitted and approved NLT COB the fifth duty day after the timecard period ends (Friday). Upon rejection of a timecard, Timecard Approvers must immediately notify the individual that their timecard was rejected along with the reason for the rejection.

NOTE: Overall responsibility for reporting MEPRS data (i.e DMHRS*i*, expenses and workload) lies with the squadron Commanders or equivalent, as designated by the Group/Wing Commander.

1.12. **All personnel working at the MTF during the reporting month will** accurately report their hours in DMHRSi NLT COB the first duty day after timecard period ends (Monday).

1.13. **Budget Analyst will** be the POC in resolving any financial data inconsistencies/problems; and will advise on all errors and required corrections to the financial data. They will also coordinate on the financial reconciliation process.

1.14. **Group Practice Manager (GPM)/Data Quality Manager (DQM) are:**

1.14.1. Crucial in resolving any data inconsistencies/problems within the MTF.

1.14.2. The DQM or GPM will review all provider profiles annually, and as needed.

1.14.3. Workload discrepancies identified by the MPM will be referred back to the work center POC with notification made to the GPM and Data Quality Manager.

2. Issue Processing:

2.1. Submit any issues to the Air Force Medical Operations Agency (AFMOA)/SGAR for resolution, as outlined in DoD 6010.13-M Chapter 4. All unresolved issues, along with comments and proposed resolution will be forwarded to Air Force Medical Support Agency (AFMSA)/SG8YR ATTN AF MEPRS Program Manager, AFMSA/SG8YR.

2.1.1. AFMSA/SG8YR logs and reviews all guidance issues for duplication, conformity to MEPRS principles, clarity, and completeness. The AF MEPRS Program Manager will coordinate with the appropriate Air Force Consultant(s). Feedback will be provided to AFMOA MEPRS Manager for distribution to the MTFs.

3. Data Submission:

3.1. **Data submission suspense:** Each Air Force Fixed MTF is required to submit Medical Expense and Performance Reporting System (MEPRS) data monthly, 45 days after the end of the data month. Medical facilities that are subordinate to a reporting medical facility do not submit separate reports since their workload and expense statistics are combined into the parent facility's report.

3.1.1. Each reporting facility forwards the monthly MEPRS files to the EASIV Repository after validation, reconciliation and allocation has been completed, no later than 45 days after the close of the reporting month; if later than 45 days annotate the reason for delinquency on the Data Quality Statement.

3.1.2. **Reports required for monthly backup:** As a minimum, the following monthly reports must be saved electronically using the following naming conventions:

NOTE: Monthly Data should be saved and retained for five years, ensure if corrections are made the saved files are updated.

3.1.2.1. Expense Allocated FCC Summary – Exp Summary MoYr_DMIS ID

3.1.2.2. Cost Table Report – Cost Tbl Rpt MoYr_DMIS ID

3.1.2.3. Personnel Detail Report – Pers Det MoYr_DMIS ID

3.1.2.4. Pure Financial Report – Pure Fin MoYr_DMIS ID

3.1.2.5. Financial Audit Report – Fin Audit MoYr_DMIS ID

3.1.2.6. EASIV Summary View Report – Summary View Mo_Yr DMIS ID

3.1.3. Refer to the MEPRS Processing Timeline Matrix for specific completion timelines.

3.2. Facilities listed in subordinate paragraphs are designated as Limited Scope Medical Treatment Facilities (LSMTFs) and are not required to process MEPRS data. LSMTFs perform a predominately Family Medicine Mission to a generally AD Population and there is no need for further granulation of these units data. The AF also has several Aid Stations that are minimally staffed to perform immediate medical care and are also not considered for MEPRS reporting.

3.2.1. McChord – DMIS ID 0395 – 62nd Medical Flight

3.2.2. Croughton – DMIS ID 0653 – 422nd ABS Medical Flight

3.2.3. Upwood – DMIS ID 0814 – 423rd ABS Medical Flight

3.2.4. Gielenkirchen – DMIS ID 0799th – 470th Medical Flight

3.2.5. Fairford – DMIS ID 0815 – 7040th ABG Medical Flight

3.2.6. Izmir – DMIS ID 0825 – 425th ABS Medical Flight

3.2.7. Menwith Hill – DMIS ID 7434th – Menwith Hill

3.2.8. Pope – DMIS ID 0355 – 43rd Medical Flight

3.2.9. LSMTFs are still to process their data within CHCS, and submit WWR/DOWR/SADR/CAPER information with the existing reporting timelines. This information will be used for historical information and support business planning.

3.2.10. LSMTFs will not be expected to perform a monthly Data Quality Statement; they will receive DQ evaluation, provider training, from the host MTF.

Section B—General MEPRS Processes

4. Purpose: The purpose of MEPRS is to identify the cost of care provided in Medical Treatment Facilities by product line and beneficiary category. MEPRS ties the expenses incurred with the FTEs and workload generated in each MTF by Functional Cost Code (FCC).

4.1. **MEPRS Coding:**

4.2. **The Basic Coding Approach:** All MEPRS activities are categorized into one of the following seven functional categories as shown in Table 4.1.

Table 4.1. MEPRS Functional Categories.

A - Inpatient Care	D - Ancillary Services	G – Medical Readiness
B - Ambulatory Care	E – Support Services	
C - Dental Care	F – Special Programs	

4.2.1. **Summary Accounts:** A summary account is a two-letter designator that groups major functions within functional categories. As shown in Table 4.2.

Table 4.2. MEPRS Summary Accounts.

Functional Category	Summary Account
A - Inpatient Care	AA - Medical Care
	AB - Surgical Care
	AC - Obstetrical and Gynecological Care
	AD - Pediatric Care
	AE - Orthopedic Care
	AF - Psychiatric Care
	AG - Family Practice Care
B - Ambulatory Care	BA- Medical Care
	BB - Surgical Care
	BC - Obstetrical & Gynecological Care
	BD - Pediatric Care
	BE - Orthopedic Care
	BF - Psychiatric and/or Mental Health Care
	BG - Family Practice Care
	BH – Primary Care
	BI – Emergency Medicine
	BJ – Flight Medicine
	BL – Physical Therapy

4.2.2. **Sub-Accounts:** A third and fourth letter identify a sub-account that describes the actual activities of an MTF as shown in table 4.3. A complete list of AF Approved Functional Cost Codes (FCCs) is provided by the Air Force MEPRS Program Manager annually.

Table 4.3. MEPRS Sub Accounts.

Functional Category	Summary Account	Sub Account
A - Inpatient Care	AD - Pediatric Care	ADAA – Pediatrics
		ADBA – Nursery
		ADDA - Adolescent Pediatrics
B - Ambulatory Care	BC – OB/GYN	BCBA – GYN Clinic
		BCCA – OB Clinic

4.3. **Work Center Definition:** A work center is a discrete functional or organizational subdivision within an MTF authorized to accumulate and measure expense, workload, manpower utilization and performance.

4.3.1. The following criteria listed below must be met before establishing a work center and assigning an FCC; it must:

4.3.1.1. Have compatibility with the Unit Manning Document (UMD) or other allocated manpower.

4.3.1.2. Have identifiable expenses.

4.3.1.3. Have allocated physical space.

4.3.1.4. Have valid work function as defined by DoD 6010.13-M or an AF special interest program (Attach 2).

4.3.1.5. Have a uniqueness of service provided or expenses incurred when compared to other established work centers.

4.3.1.6. Have Executive Leadership coordination.

NOTE: FCCs not listed on the AF Master ASD or PEMAP will not be entered into CHCS/AHLTA or other systems without approval from AFMOA.

4.4. **Establishing Functional Cost Codes (FCC):** Establishing the FCC for a new work center shall be made in coordination with basic coding guidance. FCCs and related data, as defined by the Account Subset Definition (ASD) form the basis for cost allocation.

4.4.1. First determine if the new work center meets above requirements.

4.4.2. MTF must receive approval from AFMOA/SGAR before new FCCs are implemented.

4.5. **Account Subset Definition (ASD):** The ASD identifies the FCCs used by an MTF, the activation date, deactivation date, if applicable, and the Responsibility Center/Cost Center (RC/CC). It specifies the Assignment Sequence Number (ASN), which is used in the allocation/purification process. It also defines the Data Sets used in the allocation and purification process (refer to Table 7.1. and 7.2. in this instruction for more information on Data Set usage). AFMOA/SGAR will validate all facilities' ASD annually.

4.5.1. The ASNs are published on the Master MEPRS Table that is released annually from the Air Force MEPRS Program Manager.

4.5.2. During budget preparation for the new Fiscal Year (FY), the MTF Budget Analyst (BA), manpower manager, MPM, and logistics office must coordinate work center RC/CCs and FCCs or FACs. The addition or deletion of work centers or FCCs must be coordinated with each affected program to ensure proper allocation of data. This will occur following the close out of the 3rd quarter.

4.5.3. Following in-house coordination, the MTF must submit the coordinated ASD to AFMOA/SGAR for review and approval.

Note: Brief all changes during Data Quality, Executive Committee and Cost Center Manager (CCM) meetings to ensure widest possible dissemination.

4.5.3.1. Coordinate with systems administrators to ensure the accuracy of tables located in Composite Health Care System (CHCS), Armed Forces Health Longitudinal Technology Application (AHLTA) or any other system(s) that interface with EASIV.

4.5.4. DoD 6010.13-M is the master document used to ensure FCCs reflects the correct workload capture and expense assignment. Responsibility Center/Cost Center (RC/CC) codes and Functional Account Codes (FACs) are matched to Functional Account Codes (FCCs) as outlined in Program Element Mapping Table. All FCCs and RC/CCs used by the budget analyst, manpower manager, and logistics office should reflect the same information. The Program Element Mapping (PEMAP) table, published annually by AFMSA/SG8YR, validates appropriate MEPRS Code RC/CC Program Element Code (PEC) Functional Account Code (FAC) usage.

4.6. **Cost Pool "X" Codes:** Cost pool codes are used in situations where time and expenses are difficult to assign directly and are used by more than one FCC because the work centers share physical space, personnel, and/or supply items. Care should be taken to ensure that all members of the cost pool benefit from all elements of the cost pool. For example, establish a cost pool when multiple Family Health Clinic teams share supplies/personnel and it is difficult to determine each clinic's use. Identify cost pools with an "X" in the third position of the FCC. The code for Family Practice Teams B (BGAB) and C (BGAC) cost pool would be "BGXA." Assign all shared personnel and expenses (i.e. supply costs, square footage, linen, etc.) to the cost pool code. Those accumulated costs are then distributed from the cost pool to the specialties within the cost pool based on workload for each specialty during the purification process.

NOTE: Clinicians are never assigned to, or able to charge time against Cost Pools.

4.6.1. Items purchased for a specific work center should be directly expensed to that work center. Any personnel salary, supply expense, contract cost or manning assist expense that can be readily identified to the pure code (BGAB or BGAC) should be reported to the specific work center.

4.7. **Unique Air Force Account Codes:** Attachment 2 contains unique Air Force account codes.

4.7.1. Air Force MTFs will not use the following FCCs listed in DoD 6010.13-M: AAN, BAR, BHA, BHB, BKA, FAA, FAC, FDB, FDD, GEB, and GEC. Third level "Z" codes may only be used with a TMA (TRICARE Management Agency) approved waiver.

Section C—Table Maintenance

5. Table Maintenance: Tables used within the EASIV system ensure personnel, financial and workload data are properly identified and aligned for correct cost allocation. All EAS and associated system tables will be reviewed and updated at least annually.

5.1. AFMSA/SG8YR will review and update the master tables.

5.2. MTFs will keep the following tables updated in EAS to reflect current year activities:

5.2.1. Account Subset Definition (ASD) Table changes are made prior to each fiscal year following AFMOA/SGAR approval.

5.2.2. The MPM will approve all FCCs (with AFMOA/SGAR authorization) in use at the MTF.

5.2.3. No MEPRS Codes will be used in CHCS/AHLTA without the AFMOA/SGAR approval. The CHCS Administrator, in coordination with the MPM, will ensure only approved MEPRS Codes are used in the CHCS Files/Tables.

5.2.4. The DQ Assurance Team will provide oversight and ensure approved MEPRS Codes are being appropriately used in the CHCS File/Table structure. Non-approved MEPRS Codes will be identified and appropriate corrective action will be coordinated by the DQ Assurance Team.

5.2.5. The EASIV Account Subset Definition (ASD) Table in EASIV will be reconciled with the CHCS Site Definable MEPRS Table prior to the annual Fiscal Year update.

5.2.6. The CHCS Administrator and MPM will complete an annual review of users who have access to add, edit or delete MEPRS Codes in CHCS.

NOTE: The CHCS/AHLTA files are built for ease of use, not for acceptance into EAS. The source system for correct FCCs is the EASIV system. The same FCCs must be reflected in CHCS/AHLTA as EASIV. The CPT and DRG files must also be synchronized to avoid errors when processing the Standard Ambulatory Data Record (SADR) and Standard Inpatient Data Record (SIDR). Ensure the same software versions are used.

Section D—Personnel Processing

6. Personnel Utilization and Salary Expense Data:

6.1. **General:** Timely and accurate control of personnel data is essential for the total success of MEPRS; personnel salary represents 60-75% of the total cost of care.

6.1.1. Personnel data generally includes both salary and Full Time Equivalents (FTEs). MEPRS defines 168 hours as 1 (one) FTE. Please Refer to Para 1.11. for the responsibilities of the work center MEPRS POCs.

6.1.2. There are a wide variety of helpful time reporting tools you can refer to for more detailed time reporting requirements, such as the MEPRS Quick Reference Time Matrix, and DoD 6010.13-M Appendix 3.

6.2. The following personnel must submit their timecards NLT COB the first duty day after timecard period ends (Monday). Timecard Approvers must approve or reject timecards NLT COB the third duty day after timecard period ends (Wednesday). All rejected timecards must be corrected, re-submitted and approved NLT COB the fifth duty day after the timecard period ends (Friday). Upon rejection of a timecard, Timecard Approvers must immediately notify the individual that their timecard was rejected along with the reason for the rejection.

6.2.1. United States active duty military personnel assigned and borrowed (e.g. manning assistance) to the facility.

6.2.2. Federal civilian employee assigned or borrowed to the facility.

6.2.3. Foreign national employees (direct and indirect hire) paid from appropriated funds.

NOTE: Indirect hires are foreign national personnel working within our facilities who are in-place as a result of an agreement between the U.S. and a foreign government.

6.2.4. Military medical program students (e.g. phase II, interns, residents, etc.) working in or assigned to the facility to complete training requirements.

6.2.5. Contract personnel working in the facility. These personnel submit only available hours (FTEs). Their salary (Financial Compensation) is reflected in the financial system.

6.2.5.1. If the contract doesn't require personnel to report the number of work hours, the work center POC will refer to the Quality Assurance Personnel (QAP) to determine the hours worked based on the statement of work.

6.2.5.2. Do not include day workers in the facility that is covered by a service contract (e.g. Copier Repair, or base CE personnel). These personnel are considered part of the services paid by the contract.

6.2.6. Reserve, Air National Guard and Independent Medical Augmentee (IMA) personnel assigned to serve their tour at the facility. Personnel will report in accordance to current DMRHSi business rules.

6.2.7. Patient Squadron Personnel: Active duty members assigned to the patient squadron may help within the facility and their time is captured as borrowed personnel. Members of the Patient Squadron will use their appropriate Grade/Rank but will be assigned occupation codes that define the work that they are supporting. (i.e. 4A051-Enlisted Admin, 41A3-Officer Admin).

6.2.8. Borrowed Personnel: Personnel borrowed from outside the facility (not on the MTF Unit Manning Document (UMD)) will report their time and salary to the work centers they are supporting. An example of borrowed personnel would be the Squadron Medical Elements (SMEs) who are assigned to a flying squadron but provide services within the MTF. Track available time to the benefiting work centers for borrowed personnel, and report the remainder of their time to FCGA – Support to Non-MEPRS

Reporting Military Activities, the total time they report should represent the total amount of time they worked during the reporting month.

6.2.8.1. Time for the entire pay period needs to be accounted for so that salary distribution to clinical services is accurate.

6.2.8.2. Borrowed personnel will report time, until they are no longer performing recurring duties in the facility.

6.2.8.3. If borrowed personnel (SMEs) are deployed from their unit, do not report any deployment time for them.

6.2.9. Volunteers, included, as volunteers are students utilized under an MOU with local colleges or facility programs such as Red Cross, Dental Assistant Program or pharmacy students. Only working hours be reported for volunteers; there is no salary compensation.

6.2.10. All Non-DHP Employees working in Non-DHP programs such as ADAPT, Family Advocacy, SNIAC and Health and Wellness Centers will report their time to the appropriate FAZ* (F,H,N,S, or Y) Account.

6.3. Collect time until the member is no longer assigned (military and civilian), or working (borrowed, contract and volunteers, etc.) in the MTF.

Note: Report active duty departing personnel until their Report No Later than Date (RNLTD) or day before they sign in at their next unit.

6.3.1. For personnel, who are AWOL, continue to collect time for only the first 30 days. If the individual(s) are gone for longer than 30 days, depart them from the facility. Time reporting for members beginning terminal leave ends upon the effective retirement/separation date; report active duty departing personnel until their Report No Later than Date.

6.3.2. When personnel process out for a PCS, retirement, or separation, report their time following their departure from the facility to the RNLT date, final duty day or separation date to FDGA – PCS/ETS Related Functions.

6.3.2.1. The time they spend attending out-processing appointments will be charged to FCGA – Support to Non-MEPRS Reporting Activities.

6.3.3. If a member is going to school en-route, report only the school time under FAL* - Continuing Education (CE). Attending PME will be captured in GBA – Readiness Training.

6.3.4. When personnel are working outside of the MTF the entire month (deployed or TDY) or on leave it is not appropriate to report more than the total number of regularly scheduled duty hours in the reporting month. Keep in mind; we are trying to appropriately allocate the salary to the work produced.

6.3.5. Time will not be captured or reported for civilian employees paid from non-appropriated funds or direct and indirect hire foreign national employees in an unpaid absence status time would not be captured for reporting.

6.3.6. Civilians on leave without pay will report their time in DMHRS*i* under task code 02.04. The timecard will reject in DMHRS*i*, during reconciliation, if hours are not input to match the civilian pay timecard.

6.4. The MPM will be responsible for importing the DMHRS*i* DoD EASIV*i* Create File into the EASIV. Refer to the DMHRS*i* End of Month Manual (EOM) for step by step instructions.

6.5. The three types of FTE data are assigned, available, and non-available. DoD 6010.13-M, Chapter 3, defines the use of available and non-available time. Refer to Appendix 3 for a list of standard reporting scenarios.

6.5.1. Available FTEs are based on hours worked. Available FTEs are calculated by dividing available hours in a given work center by 168 (1 FTE equals 168 hours).

6.5.2. Assigned FTEs are based on the actual number of days during each month an individual is assigned to the MTF. Assigned FTEs are not based on hours, but the percent of time actually assigned to a work center any given month. Military personnel report **all** hours spent in support of mission requirements, including work performed at home. Civilian personnel will report approved overtime/compensatory time.

6.5.3. Non-available FTEs include leave, sick (quarters/hospital admission), and military other (AD only).

6.5.3.1. Leave is charged in accordance with normal duty hours (schedule).

6.6. Military salaries are standard rates based on composites of all pay, allowances, and entitlements updated annually (IAW AFI 65-503, U.S. Air Force Cost and Planning Factors). Grade/Salary tables for Military will be provided to DMHRS*i* annually from the Air Force MEPRS Program Manager as soon as they are available.

6.7. Civilian salaries are provided to DMHRS*i* by an interface with DCPS.

6.8. Available FTEs are applied against the Grade/Salary Table to calculate personnel costs. Salary expense for non-available time is charged to the assigned work center.

6.9. The Grade/Salary Table reflects the monthly cost per FTE and is the maximum amount that will be distributed. For example, if monthly salary is $2,500.00 and the hours reported are 160 available and 32 non-available, then the total FTEs would be 1.14. The amount distributed would still be $2,500.00.

6.10. **Methods of Data Collection:** Defense Medical Human Resource System *internet* (DMHRS*i*) is the directed methodology of personnel time capture.

6.10.1. The MHS, in fulfilling a Deputy Secretary of Defense mandate to simplify and centralize medical personnel asset visibility, has chosen DMHRS*i*, a Commercial-Off-The-Shelf (COTS) integrated Human Resource Management System. DMHRS*i* is intended to provide the MHS with an Automated Information System (AIS) that integrates HR data from multiple information sources and allows real-time access to essential manpower, HR, Labor Cost Assignment (LCA), Education and Training (E&T), and readiness information across the MHS enterprise.

6.10.2. The Deputy Surgeon General (DSG) has mandated the use of the LCA, HR, and Manpower modules. The single most important factor for the Air Force is that DMHRS*i*

will serve as a source system for manpower, human resources and readiness. The primary need for DMHRS*i* within the AFMS is to support functional processes for LCA, the critical labor source feed for the Medical Expense and Performance Reporting System (MEPRS), and the need for visibility of management data on all personnel working for the AFMS and subsequently the entire DoD Military Health System (MHS).

6.10.3. The HR asset for the MTFs consists of the following personnel types: active duty, guard, reserve, civilian or government service, contractor, local national and volunteer. HR assets can either be assigned to an MTF or borrowed from another military facility in order to fulfill specific functions within the MTF.

6.10.4. Personnel data for active duty, guard, and reserve personnel is fed from the Military Personnel Data System (MILPDS) and data for government civilian service personnel is fed from the Defense Civilian Personnel Data System (DCPDS). Personnel data for contractors, local nationals and volunteers must be manually entered. HR personnel at each MTF will be responsible for the management of DMHRS*i* HR records for all person types throughout the employment life cycle, as outline in the DMHRS*i* Concept of Operations (CONOPS). A list of the HR roles and responsibilities are listed in DMHRS*i* CONOPS Usage Policies.

6.10.5. The responsibility of HR personnel at each site is to effectively manage and update the DMHRS*i* HR records so that Senior Leadership has full visibility of all person-types working in a particular site and also visibility of all person-types enterprise wide. It is critical the site HR personnel perform record maintenance tasks and maintain the 18 essential data elements, as outlined in the DMHRS*i* CONOPS.

6.10.6. The LCA, HR, and Manpower integrated management of DMHRS*i* is critical. Each MTF will form a Functional Integrated Working Group (FIWG) consisting of primary points of contract for each module to provide oversight to the DMHRS*i* processes, ensure it is used to its fullest potential, foster communication between functional areas, and recommend process changes to the MTF/CC.

Section E—Data Sets Workload

7. General: This section describes the workload data requirements of the MEPRS and includes an explanation of the applicability of existing Air Force data collection procedures to the MEPRS data requirements**.**

7.1. **Workload** is captured in a data set that is used for allocation to quantify the amount of work accomplished by a work center. DoD 6010.13-M defines specific allocation factors for the various workload data. Air Force guidance and procedures will further define specific workload reporting requirements. Workload is associated with both patient care and non-patient care activities. Coordination with work center personnel, Data Quality Assurance Team, the CHCS/AHLTA Data Base Administrator(s), and the MPM is crucial in establishing local workload validation procedures. The Group Practice Manager must be an integral part of all workload-capturing processes.

7.1.1. All workload factors will be covered in this document. Not all work centers documented on the master Accounts Subset Definition (ASD) File will be used by all facilities. The Unit Manpower Documents (UMD) will be the starting point to determine

which codes should be reported in the system. For further guidance contact AFMOA/SGAR.

7.1.2. Coordinate with appropriate work center personnel to determine the most efficient and effective means of acquiring the manually collected data. Implement additional procedures required by MEPRS reporting requirements as necessary.

7.1.3. If a work center closes, contact AFMOA/SGAR for appropriate actions.

7.2. **Data Sets:** A Data Set identifies and collects different types of workload factors, expenses, FTEs, weighted factors, and other information such as square footage, in a prescribed format. Data Sets summarize workload data by FCC and show which work centers benefit from a particular service.

7.2.1. Table 7.1. is the automated and manually generated Data Set Standard Table and reflects how data is input into EASIV. S indicates system-generated data and M indicates data that is manually tracked and input to EASIV. For system-generated data, the Workload Assignment Module (WAM) must be used. Automated workload captured in CHCS will be transmitted via the WAM for use in the EASIV System. The CHCS data is summarized for entry into EASIV using generated reports in WAM, and must be validated prior to being transmitted to EASIV.

Table 7.1. Data Set Standard Table.

* Identifies any valid MEPRS Code #### Identifies appropriate DMIS ID for reporting facility

Data Set ID	Data Set Description	Input Method Indicator
OBD	OCCUPIED BED DAYS (TO INCLUDE BASSINET DAYS)	S - CHCS
ADM	ADMISSIONS	S - CHCS
DISP	DISPOSITIONS	S - CHCS
OUTPT VISITS	OUTPATIENT VISITS	S - CHCS
TOTAL VISITS	TOTAL VISITS (IN&OUT TO INCLUDE APVS & OBSERVATIONS)	S - CHCS
DENTAL WTD PROC	DENTAL WEIGHTED PROCEDURES	M - Manual
SQ FT	SQUARE FOOTAGE	M - Manual
EIA MEALS	MEALS SERVED	M - Manual
EIB MEALS	MEALS SERVED	M - Manual
WTD NUTR PROCS	WEIGHTED NUTRITIONAL PROCEDURES	M - Manual
CLAIMS BILLED	TOTAL CLAIMS BILLED BY WORK CENTER	S – CHCS - Inpt M – Manual - all else
F ACCOUNTS - RAW PROC	SPECIAL PROGRAM ACCOUNTS - RAW PROCEDURES	M - Manual
F ACCOUNTS - WTD PROC	SPECIAL PROGRAM ACCOUNTS - WTD PROCEDURES	M - Manual
G ACCOUNTS	MEDICAL READINESS ACCOUNTS	M - Manual
SQ FT CLEANED	SQUARE FOOTAGE CLEANED	M - Manual
AMB WTD PROC	AMBULATORY WEIGHTED PROCEDURES	M - Manual
DAA*/####	PHARMACY WEIGHTED PROCEDURES	S - CHCS
DBA*/DBD*/DBE*/####	LABORATORY WEIGHTED PROCEDURES	S - CHCS
DBB*/####	LABORATORY WEIGHTED PROCEDURES	M - Manual
DCA*/DIA*/####	RADIOLOGY/NUCLEAR MEDICINE WEIGHTED PROCEDURES	S - CHCS

Data Set ID	Data Set Description	Input Method Indicator
DDA*/DDB*/DDC*/####	ECG/EEG/EMG WEIGHTED PROCEDURES	M - Manual
DDE*/####	CARDIAC CATHERIZATION WEIGHTED PROCEDURES	M - Manual
Data Set ID	Data Set Description	Input Method Indicator
DEA*/####	CENTERAL STERILE SUPPLY HOURS OF SERVICE	M - Manual
DFA*/DFB*/DFC*/####	ANESTHESIOLOGY/ SURGICAL SUITE/ POST ANESTHESIOLOGY MINUTES OF SERVICE	M - Manual
DGA*/####	AMBULATORY PROCEDURE UNIT MINUTES OF SERVICE	M - Manual
DGB*/DGD*/####	DIALYSIS MINUTES OF SERVICE	M - Manual
DGE*/####	AMBULATORY NURSING SERVICES MINUTES OF SERVICE	M - Manual
DHA*/DDD*/####	RESPITORY/PULMONARY WEIGHTED PROCEDURES	M - Manual
DJ**/####	INTESIVE CARE UNIT HOURS OF SERVICE	M - Manual
EDG*/####	TRANSPORTATION MILES DRIVEN	M-Manual
EEA*/####	MEDICAL LOGISTICS $ VALUE OF SUPPIES/EQUIP ISSUED	M-Manual
EGA*./####	BIOMEDICAL EQUIPMENT REPAIR HOURS OF SERVICE	M-Manual
EHA*/####	POUNDS OF LAUNDRY	M-Manual

* Identifies any valid MEPRS Code #### Identifies appropriate DMIS ID for reporting facility

7.3. **Data Sets are used for:**

7.3.1. **Allocation** is defined as cost assignment of intermediate operating expense accounts (D & E Accounts).

7.3.2. **Purification** is defined as cost assignment of cost pool accounts.

7.3.3. Refer to Table 7.2. Data Set Business Rules and other guidance supplied by AFMSA/SG8YR to ensure accurate reporting. Coordinate with appropriate work center personnel to determine the most efficient and effective means of acquiring the manually collected data. Implement additional procedures required by MEPRS reporting requirements as necessary.

7.3.4. **Table** 7.2. represents all Data Sets used in EASIV. It also identifies the workload factor indicator and the FCCs allowed/not allowed on the Data Sets and identify data elements that can be edited.

Table 7.2. Data Set Business Rules Table (# identifies FY – FY11 would be Br Id 1101 for OBD).

Data Set Business Rules

Data Set Br Id	Data Set Br Desc	Data Set Ind Incl	Fcc Incl	Fcc Excl	Editable Ind
#01	OBD, DISP, ADM	RAW	A%	__X_	Y
#02	INPATIENT COST POOLS	RAW, WTD	A%, B%, C%, FC%	__X_	Y
#05	VISITS	RAW	B%, FBN%	__X_	Y
#06	DENTAL	WTD	C%	__X_	Y
#07	WTD PROC WITH COST POOLS - DAA%, DAZ%	RAW, WTD	A%, B%, C%, D%, F%, G%, __X_	E%	Y
#08	DCA%, DCZ%, DBB%, DBD%, DBE%, DBF%, DBZ%	RAW, WTD	A%, B%, C%, D%, F%	__X_	Y
#09	DCX%	WTD	BAS%, D%	__X_	Y
#10	DDA%	WTD	A%, B%, C%, D%, F%	__X_	Y
#11	DDD%, DDE%	RAW,WTD	A%, B%, FB%,FC%	__X_	Y
#12	DGX%	WTD	A%, B%, D%	__X_	Y
#13	DDZ%	RAW,WTD	A%, B%, FB%, FC%	__X_	Y
#14	DEA%	WTD	A%, B%, C%, D%, F%, G%, __X_	E%	Y

Data Set Br Id	Data Set Br Desc	Data Set Ind Incl	Fcc Incl	Fcc Excl	Editable Ind
#16	DGA%	RAW,WTD	A%, B%, CA%, FC%	__X_	Y
#17	DGB%	RAW,WTD	A%, B%, FC%	__X_	Y
#18	DGD%	RAW,WTD	A%, B%, FC%	__X_	Y
#19	DGE%, DGZ%	RAW,WTD	A%, B%, CA%, FC%	__X_	Y
#20	DHA%, DHZ%	RAW,WTD	A%, B%, C%, FB%, FC%, FE%	__X_	Y
#21	DIA%, DIZ%	RAW,WTD	A%, B%, C%, FB%, FC%	__X_	Y
#22	DJA%, DJB%, DJC%, DJD%, DJE%, DJZ%	RAW	A%, B%,FC%	__X_	Y
#23	ANCILLARY COST POOLS	WTD	D%	__X_	Y
#24	DEZ%, EAZ%, EDZ%, EEA% , EEZ%, EIZ%	WTD	A%, B%, C%, D%, E%, F%, G%, __X_		Y
#25	EBD%	WTD	A%, B%, C%, D%, EBF%, F%	__X_	Y
#26	EBE%	WTD	A%, B%, D%, E%, F%	__X_	Y
#27	EBH%	RAW	A%, B%, C%, D%, F%,	__X_	Y
#28	EBI%	WTD	ABF%, C%, F%	__X_	Y
#29	EGA%	WTD	A%, B%, C%, D%, E%, F%, G%, __X_		Y
#30	EIA%	WTD	A%, B%, C%, FEC_, FEF_	__X_, ADB_, AGH_	Y
#31	EIB%	WTD	EIA%, FDC%	__X_	Y
#32	EIC%	WTD	A%, B%, C%	__X_	Y
#33	EL%	WTD	A%, B%, C%, D%, F%	E%, G%, __X_	Y

Data Set Br Id	Data Set Br Desc	Data Set Ind Incl	Fcc Incl	Fcc Excl	Editable Ind
#35	ALL CODES	RAW	A%, B%, C%, D%, E%, F%, G%	__X_	Y
#36	F ACCT RAW PROC	RAW	FAC_, FAF_, FBI_, FBJ_, FBK_, FEA_, FEC_, FEF_	FAA_, FAB_, FBE_, FBL_, FBN_,FDH_, FDI_, __X_	Y
#37	G ACCT	WTD	GE%	__X_	Y
#38	F ACCT WTD PROC	WTD	FAA_, FAB_, __X_	A%, B%, C%, D%, E%, FAC_, FAF_, FBE_, FBI_, FBJ_, FBK_, FBN_, FDC_, FDH_, FDI_, FEA_, FEC_, FEF_, G%	Y
#39	DENTAL DEPRECIATION	RAW	C%	__X_	Y
#40	SPECIAL PROGRAMS DEPRECIATION	RAW	F%	__X_	Y
#41	STD FTE & GENERIC AMOUNT COST POOLS - E, F, & G	WTD	A%, B%, C%, D%, E%, F%, G%	__X_	Y
#42	READINESS DEPRECIATION	RAW	G%	__X_	Y
#43	WTD PROC WITH COST POOLS - DBA%	RAW,WTD	A%, B%, C%, D%, F%, __X_	E%	Y
#44	DDB%, DDC%	WTD	A%, B%, FB%, FC%	__X_	Y

7.4. **Workload accuracy and reconciliation:** Workload accuracy and reconciliation is the responsibility of the performing work center. The MPM in cooperation with appropriate MEPRS work center POCs and work center managers will establish a process to conduct workload validation, including assigning responsibility for validating data accuracy, data correction, and accurate reporting. Significant workload inconsistencies will be corrected at the data source by the work center and EAS will be updated accordingly. Consult AFMOA/SGAR for additional guidance.

7.5. **Work Center Specific Workload Validation:** Workload reconciliation is a monthly requirement to be performed by the MPM. To reconcile, compare the following reports Monthly Statistical Report (MSR), Worldwide Workload Report (WWR) and the Workload Assignment Module (WAM). EAS workload should be the same as the data reflected in the WWR. Both data sets represent data as of the point in time when the reports are generated and therefore may be different. Identified anomalies will be reported to the Data Quality Manager.

NOTE: If End of Day Processing has not been accomplished, the *End-of-Day Delinquency Report* will print instead of the *Monthly Statistical Report.*

NOTE: The Biometric Data Quality Assurance Service (BDQAS) WWR suspense is no later than the 5th duty day after the month has ended, and WAM is usually generated later in the month. The TMA Suspense for the WWR is 10th calendar day. The BDQAS suspense will be used for AF reporting.

7.5.1. **Inpatient Workload (A Accounts):** Ensure proper FCCs are identified in CHCS Reports to identify the type of care the patient is receiving based on the specialty of the primary provider of care. Ensure inpatient ancillary requests contain the appropriate requesting inpatient FCC that is used during the inpatient stay while prescriptions issued at the time of discharge is properly assigned to the appropriate outpatient work center. Ensure workload has corresponding FTEs and expenses.

Performance Factors: Admissions (ADM), Occupied Bed Days (OBD), Dispositions (Disp) and Relative Weighted Products (RWPs).

7.5.2. **Outpatient Workload (B Accounts):** Capture the workload where the care is provided (example: Provider assigned to Internal Medicine and sees a patient in Family Practice, the visit will fall under the Family Practice FCC). If the provider sees a patient in other than their normally assigned clinic, both workload (encounter) and ancillary services (Lab, Rad, Pharmacy etc,) and time (DMHRS*i*) will be reported in the clinic where resources were consumed. Refer to the AFMS Workload Guidelines for specific workload reporting guidance. All workload must have corresponding FTEs and expenses**.**

Performance Factors: Total Visits, Outpatient Visits and Relative Value Units (RVUs)

7.5.3. **Dental Workload (C Accounts):** The MPM will receive the Monthly Dental Weighted Values (DWVs) and the Composite Lab Values (CLVs) from the Base Dental Summary Report (BDSR). The source data will be MEPRS DWV and MEPRS CLV Values for MEPRS Reporting. Ensure the workload has corresponding FTEs and expenses.

Performance Factors: Dental Weighted Values (DWVs) and Composite Lab Values (CLVs)

7.5.4. **Ancillary Services (D Accounts):** Workload data reported within the Ancillary datasets will be used to allocate ancillary costs back to the requesting work centers. Use the MEPRS Group Report or other applicable ancillary report from CHCS to reconcile with EASIV ancillary datasets.

7.5.4.1. **Pharmacy (DA):** Ensure requesting work centers are accurately reported by reviewing workload products for invalid codes and coordinate with the CHCS Data Base Administrator to eliminate these codes in CHCS annually. Ensure the workload has corresponding FTEs and expenses. Use the PHR MEPRS Group report to validate pharmacy workload reported in WAM.

Performance Factors: Raw-Number of Scripts, Weighted-Weighted Value of Scripts.

Allocation methodology: Weighted Value of Scripts.

7.5.4.2. **Clinical Pathology (DBA), Cytogenetic Laboratory (DBD), and Molecular Genetics Laboratory (DBE):** Ensure requesting work centers are accurately reported by reviewing workload products for invalid FCCs and coordinate with the CHCS Data Base Administrator to eliminate these codes in CHCS. Ensure the workload has corresponding FTEs and expenses. Use the LAB Group MEPRS report to validate laboratory workload reported in WAM.

Performance Factor: Raw-Number of Procedures, Weighted- CPT Value of Test Performed.

Allocation methodology: Weighted Value of Tests Performed.

7.5.4.2.1. **Anatomical Pathology (DBB):** Ensure requesting work centers are accurately reported by reviewing workload products for invalid FCCs and coordinate with the Co-Path Data Base Administrator to eliminate these codes in the system. Ensure the workload has corresponding FTEs and expenses.

Performance Factor: Raw-Number of Procedures, Weighted- CPT Value of Test Performed.

Allocation methodology: Weighted Value of Tests Performed.

7.5.4.3. **Diagnostic Radiology (DC) and Nuclear Medicine (DI):** Ensure requesting work centers are accurately reported by reviewing workload products for invalid FCCs and coordinate with the CHCS Database Administrator to eliminate these codes in CHCS. Ensure the workload has corresponding FTEs and expenses. Use the RAD MEPRS Group report to validate radiology workload reported in WAM.

Performance Factor: Raw-Number of Procedures, Weighted- CPT Value of Test Performed.

Allocation methodology: Weighted value of Tests Performed.

7.5.4.4. **Special Procedure Services (DD) (i.e. electrocardiograms, pulmonary function tests, sleep studies, etc.):** MTFs with a separately defined cardio or pulmonary function, or those which have work centers that conduct studies in one place on behalf of other clinics in the MTF or civilian network providers, will establish a non-count clinic with non-count appointment types in CHCS in the appropriate "D" FCC, to capture the workload and generate SADR encounters for all workload done. The provider responsible for reading these tests will also capture their workload in a non-count clinic with non-count appointment type in the same "D" FCC, and will also generate SADR records. The provider will capture their time spent reading these tests in the appropriate "D" FCC. All workload is manually entered into EASIV. The recommendation is to generate as much of the data as possible through CHCS. CHCS data will be the source data system. Any remaining data not included in the CHCS generated data will be provided to the MPM within the prescribed timeframe.

Performance Factor: Raw-Number of Tests, Weighted – CPT Value of Test Performed.

Allocation methodology: Weighted Value of Tests Performed.

7.5.4.4.1. **Pulmonary Function (DDD), Electrocardiography (DDA), Electroencephalography (DDB), Electroneurography (DDC), and Inhalation Respiratory Therapy (DHA):** Ensure requesting work centers workload is accurately reported. Refer to preceding paragraph for instructions on how to capture this workload. Ensure the workload has corresponding FTEs and expenses. EASIV requires entry of raw number of cases by CPT Code and will automatically calculate weighted values.

Performance Factor: Raw-Number of Cases, Weighted- CPT Value of Test Performed.

Allocation methodology: Weighted Value of Tests Performed.

NOTE: If a clinic owns an EKG/EEG/EMG machine, the (DD) workload would be captured and coded as part of the episode of care, it would not need to be broken out by the separate DD Code.

7.5.4.5. **Central Sterile Supply (DE):** A local method should be developed to determine accurate workload reporting by FCC hours of service. These hours should be inclusive of preparation, cleansing, sterilization and distribution etc., see DoD 6010.13-M for guidance. Ensure the workload has corresponding FTEs and expenses. Coordination with work center personnel will provide appropriate time for reporting purposes.

Performance Factor: Weighted-Hours of Service.

Allocation methodology: Hours of Service.

NOTE: Several smaller facilities have incorporated the CSS service with the Dental CSS operation, in this instance, all of this workload should be tracked as CSS work, unless dental is the only benefiting work center. Contact AFMOA/SGAR for further guidance.

7.5.4.6. **Anesthesia (DFA), Surgical Suite (DFB), Post Anesthesia Care Unit (DFC), Ambulatory Procedure Unit (APU) (DGA) and Ambulatory Nursing Services (DGE):** Ensure proper workload reporting is occurring in the MTF either electronically or manually. Use the methodology as described in DoD 6010.13-M. Coordinate with surgery department for collection of data. Ensure the workload has corresponding FTEs and expenses.

Performance Factor: Raw-Cases, Weighted-Minutes of Service.

Allocation methodology: Minutes of Service.

NOTE: There is a relationship between Anesthesiology, Surgical Suite, and Recovery room, but there is no expectation that all 3 areas will be used for all episodes of care.

7.5.4.7. **Hemodialysis (DGB) and Peritoneal Dialysis (DGD):** Ensure proper workload reporting is occurring either through CHCS or manually. Validation will include the review of the methodology (tracking process) used to calculate these figures. The methodology will include times, numbers, and types of personnel to ensure accuracy. Ensure the workload has corresponding FTEs and expenses.

Performance Factor: Raw-Cases, Weighted - Minutes of Service.

Allocation methodology: Minutes of Service.

7.5.4.8. **Intensive Care Units (DJ):** Ensure proper workload reporting is occurring either through CHCS or manually. Validation should include the review of the methodology (tracking process) used to calculate these figures. The methodology will include times, numbers, and types of personnel to ensure accuracy. Ensure the workload has corresponding FTEs and expenses.

Performance Factor: Raw-Cases, Weighted - Hours of Service.

Allocation methodology: Hours of Service.

7.5.5. **Support Services (E Accounts):** Workload data reported within the support datasets will be used to allocate support costs back to the requesting work centers.

NOTE: Refer to Attachment 2 for Support Services FCCs using FTEs as an allocation methodology.

7.5.5.1. **Third Party Collection Program (EBH):** Ensure claims billed reflect the correct FCC for the specialty being billed. Also, ensure only appropriate FTEs are assigned to and reporting time to this work center. Personnel simply asking patients for other health insurance information in the clinics and ancillary services should not be reporting time in EBHA. The only exception would be if someone were assigned to the area for TPC support. Ensure the workload has corresponding FTEs and expenses. Validation should include verification of the provider's FCC.

Allocation methodology: Claims billed (submitted).

7.5.5.2. **Plant Management (EDA), Operation of Utilities (EDB), Maintenance of Real Property (EDC), Minor Construction (Modernization) (EDD), Other Engineering Support (EDE), Lease of Real Property (EDF), Fire Protection (EDH), and Police Protection (EDI):** These accounts support the infrastructure of the facility. Ensure the workload has corresponding FTEs and expenses as appropriate.

Allocation methodology: Square Footage.

7.5.5.2.1. **Square Footage:** All square footage of medical buildings must be reported by FCC at the start of each fiscal year and updated monthly as changes occur**.** Square footage and square footage cleaned is obtained from the Facility Management Officer using a report from Defense Medical Logistics Standard Support (DMLSS).

NOTE: Unused and facility common square footage would be reported against the plant management FCC – EDAA/**5741 – Real Property Management.

7.5.5.3. **Transportation (EDG):** The reporting of vehicle mileage is dependent on MTF-unique circumstances. Report all MTF vehicle mileage by FCC. When a work center has its own fuel card, the requirement for reporting mileage is unnecessary, as the cost is already being allocated against the using work center. If the fuel cards are shared or the MTF has GSA leased vehicles, then it is necessary to break out each user to make sure that expenses are allocated to the using work centers. Contact the Vehicle Control Officer/NCO for transportation issues. Under other circumstances, refer to AFMOA/SGAR for clarification. Ensure EDG - Transportation has corresponding FTEs and expenses as appropriate.

Allocation methodology: Miles driven.

7.5.5.4. **Medical Materiel (EE):** Report the Month Net Dollar Value of Supplies/Equipment issued (6XXXX, excluding 641, also exclude Program Element Code (PEC) 87701/87901) by FCC. The cost of operating Medical Materiel is based on the Element of Expense Investment Codes (EEICs) used by the various work centers. A ratio of 6XXXX supplies used will be used to allocate the cost of Medical Logistics. This information is found in EASIV under Standard Report section, Expense Accepted by RC/CC Report. Ensure EEA - Medical Logistics has corresponding FTEs and expenses as appropriate.

Allocation methodology: Dollar value of supplies and equipment issued.

7.5.5.5. **Housekeeping (EF):** Refer to Para 7.5.5.2.1. for information on how to report Square Footage Cleaned. Ensure the workload has corresponding FTEs and expenses as appropriate.

Allocation methodology: Square footage cleaned.

7.5.5.5.1. **Square Footage cleaned** Square footage cleaned by FCC cannot exceed square footage by FCC. For example, mechanical rooms are not cleaned under the housekeeping contract but are included in your square footage. Square footage cleaned is obtained from the Facility Management Officer using a report from DMLSS

7.5.5.6. **Biomedical Equipment Repair (EG):** Report Hours of Service by the requesting FCCs for Biomedical Equipment Repair Technician (BMET) repairs performed. Ensure the workload reported by FCC and RC/CC matches the current Program Element Mapping (PEMAP). If this work center is a regional Medical Equipment Repair Center (MERC), ensure hours spent in support of outside activities are reported under the appropriate "F" FCC. Ensure EGA - Biomedical Equipment Repair has corresponding FTEs and expenses as appropriate. The Defense Medical Logistics Standard Support (DMLSS) Medical Expense & Performance Report (MEPRS) is the source document.

Allocation methodology: Hours of service.

7.5.5.7. **Linen and Laundry (EH):** Report clean, dry pounds of laundry issued to each requesting FCC. Beginning each fiscal year, validate the weight of each clean item on the master list by the Medical Materiel Flight. Ensure EHA - Linen/Laundry has corresponding FTEs and expenses as appropriate. Actual weight by work center can be used.

Allocation methodology: Pounds of laundry.

7.5.5.8. **Food Operations (EI):** Report Meals Served by FCC. Food Service personnel will provide the MPM a copy of the Nutrition Management Information System (NMIS) Report. Ensure the workload has corresponding FTEs and expenses.

Allocation methodology: Meals served.

7.6. **System Generated Information.**

7.6.1. **Inpatient Administration (EJ):** Inpatient Administration will be allocated using the Occupied Bed Day Data Set from WAM. Ensure EJ - Inpatient Care Administration has corresponding FTEs and expenses as appropriate.

Allocation methodology: Occupied Bed Days.

7.6.2. **Ambulatory Administration (EK):** Ambulatory Administration will be allocated using the Total Visit Data Set from WAM. Ensure EK - Ambulatory Administration has corresponding FTEs and expenses as appropriate.

Allocation methodology: Total Visits.

7.6.3. **TRICARE/Managed Care Administration (EL):** TRICARE/Managed Care Administration will be allocated using the Total Visit Data Set from WAM. . Ensure EL - TRICARE/Managed Care Administration has corresponding FTEs and expenses as appropriate.

Allocation methodology: Total Visits.

7.7. **Other Data required for reporting purposes (F and G Accounts).**

7.7.1. **F Account Raw Procedures**

7.7.1.1. **Immunizations (FBI):** Workload will be the number of immunizations performed in the reporting month. Ensure FBI - Immunization has corresponding FTEs and expenses as appropriate.

7.7.1.2. **Early Intervention Services (FBJ):** Workload will be the number of active cases in the reporting month. Ensure FBJ - Early Intervention Services (Ages 0-2) has corresponding FTEs and expenses as appropriate.

7.7.1.3. **Medically Related Services (FBK):** Workload will be the number of active cases in the reporting month. Ensure FBK - Medically Related Services (Ages 3-21) has corresponding FTEs and expenses as appropriate.

7.7.1.4. **Ambulance Services (FEA):** Workload will be the hours of service that the ambulance is on runs in the reporting month. Ensure FEA - Ambulance Services has corresponding FTEs and expenses as appropriate.

7.7.1.5. **Transient Patient Care (FEC):** Workload will be the number of Occupied Bed Days (OBDs) provided to transient patients in the reporting month. Ensure FEC - Transient Patient Care has corresponding FTEs and expenses as appropriate.

7.7.1.6. **Aero Medical Staging Facility (FEF):** Workload will be the number of Occupied Bed Days performed in the ASF during the reporting month. Ensure FEF - Aero Medical Staging Facility has corresponding FTEs and expenses as appropriate.

7.7.2. **F Account Weighted Procedures**

7.7.2.1. **Area Dental Laboratory (FAB):** Workload will be the Composite Lab Values (CLVs) produced in the Area Dental Laboratory during the reporting month. Ensure FAB - Area Dental Laboratory has corresponding FTEs and expenses as appropriate. The Air Force has 3 Area Dental Labs 86th Medical Group, Ramstein AB Germany; 18th Medical Group, Kadena AB Okinawa Japan; and 21st Medical Group, Peterson AFB Colorado.

7.7.3. **G Account Workload**

7.7.3.1. **Prepositioned War Reserve Material (WRM) (GEA):** Workload will be the Dollar Value of WRM on hand at the end of the reporting month. Time and expenses would not be reported to this code unless your facility had personnel exclusively dedicated to managing the WRM Account. Generally this function is an extension of Logistic Management.

Section F—Financial Data

8. Financial Data: Includes all expenses and obligations associated with operating the MTF and meeting the organization's mission.

8.1. **Expense data** is a combination of supply, equipment, contract, depreciation, additional support and special program costs. These expenses make up the direct expenses for MEPRS reporting. Expenses are collected monthly from Defense Financial Accounting System (DFAS) using the Commander's Resources Integration System (CRIS) financial program as the source file for input into EASIV. Personnel expenses are generated with Defense Medical Human Resources System – internet (DMHRSi).

8.1.1. Financial Data reported in MEPRS are expenses-paid (AEP) and expenses-unpaid (AEU). Expenses will include all current months' transactions that affect any current or prior year financial obligation. For information only, Total Obligations (AEP+AEU+UOO) is reported for only the current year.

8.1.2. The MPM is responsible for calculating investment equipment depreciation at the beginning of each fiscal year. Only investment equipment currently in use at the MTF is depreciated. AFMOA/SGAR provides a Depreciation/Free Receipt Spreadsheet to the MTF to assist in the determination of the monthly depreciation and free receipt calculations. The following procedures apply:

8.1.2.1. The depreciation expense will be charged to one or more of the following FCCs based on location of the investment equipment: Inpatient (EAAA), Outpatient (EABA), Dental (EACA), Special Program (EADA), or Medical Readiness (EAEA).

8.1.2.2. Request Medical Logistics provide a list of investment equipment currently in use from the Equipment Management Module of the Defense Medical Logistics Standard Support (DMLSS) system: Annual Capital Equipment Depreciation Report, and the DMLSS Active Historical Maintenance Report. These reports will provide necessary information (name, nomenclature, fiscal year in which received, purchase price, and cost center) to enter into the depreciation spreadsheet.

NOTE: AFMOA/SGAR in coordination with the AFMOA/SGALD, DMLSS Program Office at Fort Detrick, and the US Army Joint Medical Asset Repository (JMAR), will disseminate a comprehensive list of all medical investment equipment to MPMs by the middle of October each year. The list will contain MTF, Work Center Description, Acquisition Date, Equipment Nomenclature, Equipment Item ID, Equipment Control Number, and Equipment Cost. MEPRS managers can use this as an alternate source of information, but need to have their Logistics section validate the list is accurate and the equipment is in use.

8.1.2.3. Do not depreciate equipment in the year of installation. If equipment becomes no longer serviceable or is removed from the facility in the course of the year, make the appropriate updates to the depreciation spreadsheet.

8.1.2.4. Investment equipment purchases are identified and separately totaled by Inpatient, Outpatient, Dental, Special Programs, and Medical Readiness purchases. The investment equipment threshold is $100,000 unless changed by AF guidance.

8.1.2.5. Apply investment equipment purchases shared by inpatient and outpatient accounts using the applicable ratio in table 8.1.

Table 8.1. Distribution Ratios for Investment Equipment (Depreciation).

Average Daily Patient Load	Inpatient	Outpatient
Greater than 100	40%	60%
Less than 100	20%	80%
Clinics		100%

NOTE: If an MTF changes from inpatient to an outpatient facility, the depreciable equipment must be moved in MEPRS to the current outpatient service using the equipment. Any inpatient depreciable equipment transferred to another facility will be deleted from the listing.

8.1.2.6. After the total dollar amount is established for inpatient and outpatient investment equipment purchases, enter it in the depreciation spreadsheet to yield the monthly depreciation expenses.

NOTE: Dividing the total investment purchases by 60 months resulting in a five-year depreciation cycle derives the monthly Depreciation Expense

8.2. Other Non-OBL Expenses are also calculated using the Depreciation/Free Receipt Spreadsheet. Base support services, fire protection, and police protection expenses are assigned in accordance with DoD 6010.13-M, Chapter 2, which designates assignment procedures governing the work center account. This expense is calculated monthly based on personnel salaries and direct expenses from EASIV using the Expense Accepted for Allocation Report. More detailed instructions are provided in the Depreciation/Free Receipt Spreadsheet. The calculations are outlined below:

8.2.1. FCC EDHA, Fire Protection, is calculated from the total expenses by multiplying ".00008 x total expenses". Enter the calculated amount in financial adjustments (expenses only).

8.2.2. FCC EDIA, Police Protection, is calculated from the total expenses by multiplying ".0007 x total expenses". Enter the calculated amount in financial adjustments (expenses only).

8.2.3. FCC EDKA, Other Base Support Services, is calculated from the total expenses by multiplying ".0015 x total expenses". Enter the calculated amount in financial adjustments (expenses only).

8.3. FCC EIBA, Combined Food Operations, expenses must be manually entered in financial adjustments. Obtain these expenses from the AF Form 544; year-to-date column or the cumulative YTD purchases from End of Month Food Services Report will be input.

8.4. **EASIV Financial Processing:**

8.4.1. The Budget Analyst (BA)/Resource Advisor (RA): will validate total expenses for all years (at RC/CC level) and obligations for current year monthly. During this process the Budget Analyst should validate accuracy of PECs, RC/CCs and EEICs. The Current Program Element Mapping (PEMAP) in conjunction with the Base AFO Funds Management (FM) Coding Package.

8.4.1.1. A financial file will be created monthly by the Budget Analyst using the Commander's Resource Integration System (CRIS) and imported into EASIV by the MPM. The Budget Analyst will coordinate with the MPM on all EASIV financial adjustments. All errors, warnings and negative numbers for expenses and obligations will be researched, explained and documented by the Budget Analyst. If corrective actions cannot be determined locally, contact AFMOA/SGAR for further guidance. Corrections will be required in the month the error occurred and all subsequent months. Re-allocation and re-transmission of each month is required. Correction will be made in the source financial system as appropriate.

8.4.1.2. The MPM will work closely with the Budget Analyst to conduct the reconciliation. The BA will coordinate requirements with the Base Financial Services Office (BFSO), Defense Financial Accounting Service (DFAS), Civilian Personnel Office (CPO), or other critical base support agencies to ensure accurate data is received and minimal edits are required. The Budget Analyst and RMO Flight Commander will sign the finalized reconciliation documentation.

8.4.1.3. Ensure financial data reported in EASIV is the same as that reported through the financial management and DFAS systems. Source data is received on the monthly financial file and must not be altered.

8.4.1.4. AFMOA/SGAR will provide oversight of financial reconciliation by conducting a quarterly comparison of EASIV financial data to financial system reported data. Discrepancies will be communicated back to the MTF for explanation and/or correction, and to ensure the audit trail is complete.

8.4.1.5. AFMSA/SG8YR will conduct a financial reconciliation annually by comparing DFAS data to EASIV. Again, any discrepancies will be communicated back to the MTF through AFMOA/SGAR for explanation and/or correction, and to ensure the audit trail is complete.

NOTE: Any changes to financial data, to include personnel salary, will necessitate updating the monthly Depreciation/Free Receipt spreadsheet (personnel expense net or financial expense net). Reallocate and retransmit as appropriate.

Section F—MEPRS Data Quality

9. Purpose: The MEPRS Program Manager in conjunction with appropriate personnel will ensure all systems' files and tables are updated and synchronized as required. Data reconciliation ensures program compliance and accuracy in collecting, coding, and reporting workload, financial, and personnel data.

9.1. The MPM will ensure initial and ongoing training of all personnel in the mechanics of MEPRS data reporting.

9.2. MTFs will use WAM for CHCS-generated workload data. Issues identified in WAM or the workload migration process that drives update to data must be made in the source file of CHCS by the responsible work center. After corrections, reinitialize WAM and resubmit file to EASIV. It would also be appropriate to regenerate and retransmit the WWR file during this process if data affected impacted data reported in WWR.

9.3. The MPM may make changes to workload data in EASIV **ONLY** if correction in CHCS/AHLTA is not possible. Changes made outside of CHCS will be coordinated with the affected work center.

9.4. Refer to Attachment 4 for specific Health Services Inspection (HSI) requirements.

Section G—Prescribed and Adopted Forms

10. Adopted Forms:

AF Form 847, *Recommendation for Change of Publication*

CHARLES B. GREEN, Lt General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DoD 6010.13-M, *Medical Expense and Performance Reporting System for fixed Military Medical and Dental Treatment Facilities, 7 April 2008*

DoD 6015.1-M, *Glossary of Healthcare Terminology, 13 January 1999*

DoDI 6040.40, *Military Health System Data Quality Management Control Procedures, 26 November 2002*

AFI 41-120, Medical *Resource Operations, 18 October 2001*

AFI 41-210, *Patient Administration Functions, 22 March 2006*

AFI 65-503, *U.S. Air Force Cost and Planning Factors, 4 February 1994*

AFI 65-601, Volume 1, *Budget Guidance and Procedures, 3 March 2005*

AFMAN 33-363, *Management of Records, 1 March 2008*

AFPD 41-1, *Health Care Programs and Resources, 15 April 1994*

Joint Federal Travel Regulation (JFTR) U5243

Air Force Records Information Management System (AFRIMS)

Expense Assignment System Version IV (EASIV) Reference Guide

MEPRS Time Reporting Matrix

PEMAP – Program Element Mapping

DMHRS*i* End of Month (EOM) Manual

DMHRS*i* Concept of Operations (CONOPS)

MEPRS Processing Timeline Matrix

AFMS Workload Guidelines

Abbreviations and Acronyms

AFPD— Air Force Policy Directive

AFRIMS— Air Force Records Information Management System

ADPL— Average Daily Patient Load

AHLTA— Armed Forces Health Longitudinal Technology Application

AIS— Automated Information System

ALOS— Average Length of Stay

AOD— Administrative Officer of the Day

APPROP— Appropriation Codes - Classification of appropriated funds

APV— Ambulatory Procedure Visit

APU— Ambulatory Procedure Unit

ASD— Account Subset Definition

ASF—Aero medical Staging Facility

ASN— Assignment Sequence Number

ASWC— Assigned Work Center

BDQAS— Biometric Data Quality Assurance Service

BMET— Biomedical Equipment Repair Technician

CAPER— Comprehensive Ambulatory Professional Encounter Record

CC— Cost Center

CDA— Central Design Activity

CE— Continuing Education (Formally Continuing Health Education – CHE)

CHAMPUS— Civilian Health and Medical Program for the Uniformed Services

CHCS— Composite Health Care System

CLV— Composite Lab Values

CMI— Case Mix Index

CONOPS— Concept of Operations

COTS— Commercial Off-the-Shelf

CPO— Civilian Personnel Office

CPT— Physicians' Current Procedural Terminology

CRIS— Commander's Resource Integration System

DES— Direct Expense Schedule

DFAS— Defense Financial Accounting Service

DMIM— Defense Medical Information Management

DMIS— Defense Medical Information Systems

DMHRSi— Defense Medical Human Resources System - internet

DMLSS— Defense Medical Logistics Standard Support

DMSSC— Defense Medical Systems Support Center

DoD— Department of Defense

DRG— Diagnostic Related Groups

DQ— Data Quality

DQM— Data Quality Manager

DQMCP— Data Quality Management Control Program

DSS— Database Sustainment Manager

DTF— Dental Treatment Facility

EASIV— Expense Assignment System, Version 4

EASIVi— Expense Assignment System, Version 4 internet

EEIC— Element of Expense & Investment Code

EOM— End of Month

FAC— Functional Account Code

FCC— Functional Cost Code

FOA— Field Operating Agency

FTE— Full Time Equivalent

FY— Fiscal Year

GPM— Group Practice Manager

HCI— Health Care Integrator

HIPAA— Heath Insurance Portability & Accountability Act

Hosp/SL— Hospital/Sick Leave

HR— Human Resources

ID— Identification

JFTR— Joint Federal Travel Regulation

JTFCAPMED— Joint Task Force National Capital Region Medical

M2— Business Object program for retrieving data from Master Data Repository (MDR)

MAJCOM— Major Command

MEPRS— Medical Expense and Performance Reporting System

MFI— Medical Facility Identification

MMIG— MEPRS Management Improvement Group

MOD— Medical Officer of the Day

MPM— MEPRS Program Manager

MTF— Medical Treatment Facility

NCOD— Non-Commissioned Officer of the Day

OASD/HA— Office of the Assistant Secretary of Defense (Health Affairs)

OBD— Occupied Bed Day

OI— Operating Instruction

PBAS— Program Budget Accounting System

PEC— Program Element Code

PEMAP— Program Element Mapping

POC— Point of Contact

QAP— Quality Assurance Personnel

QC— Quality Control

RC— Responsibility Center

RCMI— Relative Case Mix Index

RDS— Records Disposition Schedule

RMO— Resource Management Office

RWP— Relative Weighted Products

SCR— System Change Request

SEEC— Standard Expense Element Code

SIR— System Incident Report

SME— Subject Matter Expert

UIC— Unit Identification Code

WAM— Workload Assignment Module

WWR— Worldwide Workload Report

Terms

Adjustment— The process of adding, subtracting, or otherwise modifying incurred expenses or data into an array or format that reflects MEPRS recognized expenses and statistics.

Admission—The act of placing an individual under treatment or observation in a or hospital

Aero Medical Staging Facilities—Medical facilities having aero medical staging beds, located on or in the vicinity of an enplaning or deplaning air base or air strip that provides reception, administration, processing, ground transportation, feeding, and limited care for patients entering or leaving the aero medical evacuation system.

Allocation—Reassignment of expenses from intermediate (Ancillary and Support) accounts to final operating expense accounts

Ancillary Services— Services that participate in the care of patients principally by assisting and augmenting attending physicians and dentists in diagnosing and treating human ills.

Cost Assignment—The distribution or transfer of an item of cost or a group of items of cost to one or more work centers.

Cost Pool—Operating expense accounts, which collect direct or indirect operating expenses for purposes of reassignment to work center accounts and ultimately to final operating expense accounts.

Depreciation—The decrease in the service potential of equipment as a result of wear, deterioration, or obsolescence, and the subsequent allowance made for the process in the accounting records of the activity.

Disposition—The removal of a patient from the census of an inpatient facility by reason of discharge to duty, to home, transfer to another medical facility, death, or other termination of inpatient care.

Expense Assignment System (EAS)—A standard automated data processing capability utilized by the military departments for the calculations required to produce the Medical Expense and Performance Reports.

Expenses—The total of accrued expenses paid and unpaid

Migration— The process of bringing in the files (Personnel, Financial and workload) to EASIV.

Obligations—The total of accrued expenses paid and unpaid plus undelivered orders outstanding.

Service Unit—A measure of work produced by a function within an MTF such as occupied bed days, visits, procedures, square footage, etc.

Purification—Reassignment of expenses from one operating expense account to one or more other operating expense accounts

Validation— The process of checking the files (Personnel, Financial and workload) against existing tables in EASIV.

Visit—Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery of or prescription of a care regimen. Refer to DoD 6015.1-M for a more detailed description.

Attachment 2

AIR FORCE UNIQUE ACCOUNT CODES

A2.1. General: The following codes are to be used whenever a separately defined work center is established.

A2.2. EBAA – Command: This code accounts for the cost of providing command jurisdiction over all personnel assigned or attached to the medical facility. Includes cost in determining the facility's medical capability in relation to available medical service officers, supporting staff and facilities; implementing directed programs; caring for and safeguarding all property under command control; and supervising the care, treatment and welfare of the patients. Medical Wing/Group Commander, Deputy Commander (when authorized), Group Superintendent, First Sergeant; and their immediate secretarial and administrative staff will be included in this expense account. Time reported includes attendance at any official function. All personnel attending Group Commander's Call will be reported using this code.

Allocation methodology: Total Available FTEs of the facility.

NOTE: For Squadron Command functions see specific paragraphs below.

A2.3. EBBA - Special Staff: This code includes the Administrator, Chief of the Medical Staff (formerly Chief of Hospital Services), Nurse Executive, Medical Law Consultant (when authorized), Chaplain Services (when authorized), Credentials, Infection Control, Self-Inspection (when appointed by letter to perform a self-inspection), Quality Assurance and Risk Management programs, and their immediate secretarial and administrative staff. This account also includes the Dental and Biomedical Advisors when functioning as Group Staff.

Allocation methodology: Available FTEs of the facility.

A2.4. EBBH - Health Promotion Program: This code is used to account for the administration of health promotion activities to build healthier communities. The coordinator and their direct staff will have oversight of the Health and Wellness Center (HAWC) and will have to track their time in appropriate MEPRS Codes to the work that they are performing. FAZH would be used to report patient care time. The Health Promotion Coordinator will annotate committee attendance for the Installation Health Promotion Working Group, and others (i.e. Aerospace Medicine Council, Health Consumer Advisory Council, wing briefings/meetings, etc.) where health promotion representation is required or requested. The health promotion manager should count the hours for all planning, programming, executing and evaluating all health promotion activities.

Allocation methodology: Total Available FTEs of the facility.

A2.5. EBCA - Medical Resource Management Administration: This account includes the functions of Medical Resource Management Flight (RMO). Refer to AFI 41-120 for guidance.

Allocation methodology: Total Available FTEs of the facility.

A2.6. EBCB – Commander's Support Staff (CSS): This account includes the functions of the Commander's Support Staff (Orderly Room).

Allocation methodology: Total Available FTEs of the facility.

A2.7. EBCC – Committees: This account includes those committees authorized by Air Force Instructions and MTF committee regulations. Staff meetings are not included in this account. Allocation methodology: Available FTEs of the facility. Refer to attachment 3 for a general list of committees that should be included in this FCC.

Allocation Methodology: Total Available FTEs of the facility.

A2.8. EBCD - Dental Squadron: This code accounts for the cost of providing effective management of all assigned dental functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the dental squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the Dental Squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander's Call will also be reported in this code. In smaller Clinics EBCD may not be used in combination of aerospace and dental operations. The Aero medical Squadron would be developed and the EBCF code will be used for that squadron.

Allocation methodology: Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.9. EBCE - Medical Support Squadron: This code accounts for the cost of providing effective management of all assigned medical support functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the Medical Support Squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the Medical Support Squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander's Call will also be reported in this code.

Allocation methodology: Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.10. EBCF - Aerospace Medicine Squadron: This code accounts for the cost of providing effective management of all assigned aerospace medicine functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the Aerospace Medicine Squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the Aerospace Medicine Squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported should include attendance at any official functions. Squadron Commander's Call will also be reported in this code. This code may be used as an Aero dental Squadron when a Dental Squadron (EBCD) is not authorized.

Allocation methodology: Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.11. EBCH - Medical Operations Squadron: This code accounts for the cost of providing effective management of all assigned medical operations functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the Medical Operations Squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the Medical Operations Squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander's Call will also be reported in this code.

Allocation methodology: Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.12. EBCI – Inpatient Operations Squadron: This code accounts for the cost of providing effective management of all assigned inpatient operations functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the Inpatient Operations Squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the inpatient operations squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander's Call will be reported in this code.

Allocation methodology: Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.13. EBCJ - Diagnostic and Therapeutic Squadron: This code accounts for the cost of providing effective management of all assigned diagnostic and therapeutic functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating evaluating, and improving all aspects of system performance for the Diagnostic and Therapeutic Squadron. Functions also includes developing effective relationships with other group entities; defining roles and responsibilities that optimize the effectiveness of the diagnostic and therapeutic squadron; and providing oversight for education, training, and career management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander's Call will also be reported in this code.

Allocation methodology: Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.14. EBCK - Surgical Operations Squadron: This code accounts for the cost of providing effective management of all assigned surgical operations functions and resources by the Squadron Commander, senior enlisted manager, and their immediate administrative staff. Functions include planning, organizing, operating, evaluating, and improving all aspects of system performance for the Surgical Operations Squadron; developing effective relationships with other group entities; defining roles and responsibilities that optimize effectiveness of the surgical operations squadron; and providing oversight for education, training, and career

management of squadron personnel. Time reported will include attendance at any official functions. Squadron Commander's Call will also be reported in this code.

Allocation methodology: Total Available FTEs of the MEPRS codes under the purview of the squadron. Update the ASD dataset definition annually or as needed.

A2.15. EBCL – Supervision Oversight: This account will be used to track the FTEs and salary for supervisory oversight to include writing decorations, EPRs, OPRs, civilian appraisals and any personnel counseling required. This account will also be used to track all MTF directed details (Cash count, Drug Inventory, MOD, NCOD, AOD, and Casualty Assistance. This account is **NOT** to be used for any time in normally considered patient care, support to the clinic or normal day-to-day running of the clinic.

Allocation methodology: Total Available FTEs of the facility.

A2.16. EBDA – Clinical Management: This code accounts for costs of MTF Clinical Management services to include department heads, Health Care Integrators (HCIs), Group Practice Managers (GPMs) and their immediate Staff. Time spent performing Clinical Peer Reviews will also be captured under this code. This does not include day-to-day clinic operations. If a GPM supports all clinical areas they are assigned and will report a majority of their time to EBDA. If the MTF has multiple GPMs, they will be assigned to the clinical work center they support. Contact AFMOA/SGAR for further guidance.

Allocation methodology: Total Available FTEs of the clinical areas of the MTF (A, B, C, D).

A2.17. EBFN - Audiovisual Services: This code accounts for costs of audiovisual services to include medical illustration and medical photography. Costs include manpower, travel, contractual services, procurement of supplies and materials, expense equipment, necessary facilities and the associated costs specifically identified, separable into "in-house" and "contract" portions, and measurable to medical functions, productions and services and support, as appropriate.

Allocation methodology: Total Available FTEs of the facility.

A2.18. EBFW - Medical Library: This code accounts for costs of manpower, travel, contractual services, procurement of supplies and materials, expense equipment, necessary facilities and associated costs to support operation of the medical library.

Allocation methodology: Total Available FTEs of the facility.

A2.19. EBHA – Third Party Collections: See Para 7.5.5.1.

Allocation methodology: Total Claims Billed (submitted).

A2.20. ELAH – HIPAA Privacy Program: This account is used to accumulate all the operating expenses incurred in implementing and administering the Health Insurance Portability & Accountability Act (HIPAA) program within the facility. This includes administrative tasks, training (instructor), facility briefings, and ensuring all MTF personnel, including volunteers, and contractors, abide by the rules and regulations of HIPAA**.**

Allocation methodology: Total Visits.

NOTE: Personnel attending HIPAA training will charge time to FAL*-Continuing Education.

A2.21. ELAN – Case Management/Case Management Wounded Warriors: This Account is used to accumulate all the operating expenses incurred in implementing and administering Case Management Activities.

Allocation methodology: FTEs reported in A, B, FBI, FBN, and FEA.

A2.22. FALA – Continuing Education (CE): This account is used for capturing costs incurred by an MTF in support of Continuing Education (CE) requirements. This includes all CE regardless of location or source of instruction, to include in-services.

A2.23. FAZF – Family Advocacy Program: Use this account to capture the cost and FTEs of operating, maintaining, administering, and supervising the installation Family Advocacy Program, to include Family Maltreatment Services, Family Advocacy Strength-based Services, the New Parent Support Program, and the Family Advocacy Outreach Program.

A2.24. FAZH - Health and Wellness Center: This code is used to account for health promotion patient activities that are part of building healthier communities and may include a referral from a provider for a diagnosed illness or condition. Health promotion activities include administering the HEAR (Health Evaluation Assessment Review), awareness, education and interventions (including screenings) for tobacco prevention/cessation, fitness health assessment and enhancement exercise prescription, stress management, substance abuse, cardiovascular disease prevention, cancer prevention, injury prevention, and medical self-care. These activities can be conducted at work sites, through outreach programs, in the health and wellness center.

NOTE: Count Visits will not be captured in Health and Wellness Centers for the above activities. The MTF may establish a non-count clinic with non-count appointment types in CHCS/AHLTA using the FAZH FCC and code the encounter in ADM appropriately. Nutritional medicine is not part of this function and should continue to be captured in BALA.

A2.25. FAZN - Special Needs Identification and Assignment Coordination: Use this account to capture the cost of reviewing medical records, electronic encounter and treatment histories, interviewing family members, reviewing facility determination inquiries, and making recommendations for family member travel OCONUS and for special needs family member travel within CONUS. This account also includes time spent advising family members/unit representatives on procedures for the family member relocation clearance process, educating base personnel on SNIAC/EFMP requirements, data collection and reporting IAW DoD and AF requirements, and assignment coordination database/records maintenance.

A2.26. FAZS - ADAPT Program (non-clinical services): Use this account to capture the cost and FTEs of operating, maintaining, and supervising the administrative activities of the installation ADAPT Program, to include the cost of providing supervision to substance abuse counselors, maintaining and analyzing program data, providing reports, contact with commanders and other base or local personnel in relation to the ADAPT program, and alcohol abuse prevention activities conducted under the auspices of the ADAPT Program. The clinical activities performed by Clinical Mental Health staff in support of the ADAPT program are coded under the mental health clinic code.

A2.27. FAZY - Preventive Mental Health Services: Use this account to capture the cost and FTEs of briefings, workshops, and seminars provided and attended by groups for prevention education or raising awareness about mental health issues, meetings whose primary purpose is to promote the emotional health and welfare of the base community or population (e.g., CAIB and IDS), command consultation regarding specific programs, community issues, or population health, community crisis response (e.g., trauma stress response, hostage negotiation) and any other mental health promotion initiative (e.g., stress management, suicide prevention) conducted within the base community. To be coded FAZY, these activities must occur outside the mental health clinic.

A2.28. FBBB - Environmental Compliance: This account will be used to capture the costs to support installation environmental compliance. Activities are limited to compliance with environmental laws as implemented by the federal, state, and local environmental regulatory agencies. This includes, but is not limited to, the Safe Drinking Water Act, Clean Water Act, Clean Air Act, Residential Lead Based Paint Hazard Reduction Act of 1992, and Resource Conservation and Recovery Act. It includes sampling analysis and monitoring to the extent required to comply with the applicable regulatory authority and the assessment of environmental (not human health) impact of accidents and disasters such as chemical or fuel spills. For overseas bases, includes activities required to comply with the Host Nation Final Governing Standards or the Overseas Environmental Baseline Guidance Document.

A2.29. FBBC - Pollution Prevention: Accounts for the costs to support installation pollution prevention programs. This includes support of the ozone depleting substance waiver process and retrieval of hazardous material usage and storage data to support reporting requirements. It does not include the inventory and control of hazardous material required to the extent it is required by the Industrial Hygiene Program.

A2.30. FBBD - Environmental Restoration: Accounts for the costs to support installation environmental restoration programs. Includes health impact support of environmental restoration (cleanup) activities, human health assessments, and Agency for Toxic Substances and Disease Registry Agency (ATSDR) activities

A2.31. FBBE - Environmental Conservation Support: Accounts for the costs to support installation environmental conservation programs. This includes health impact review of Environmental Assessments (EA), Environmental Impact Statements (EIS), installation operations on endangered species, and other installation activities impacting cultural or natural resources.

A2.32. FBEA - Public Health: This account is used to capture all operating expenses for developing and conducting medical services surveillance programs to ensure hazards to individuals and community health are identified, evaluated and eliminated or controlled. This encompasses: identifying occupational illnesses; the control of communicable diseases; the evaluation of foods, food sources, food service facilities, and other public facilities and services used by military and DoD civilian personnel providing for and screening of occupational physical examinations for active duty personnel in hazardous occupations; monitoring public health and occupation-related physical examinations of federal civilian workers, including pre-employment, fitness for duty, termination, and disability evaluations; investigating communicable diseases and diagnosed or suspected illnesses; collating and reporting communicable disease statistics, occupational illnesses, and other health data; conducting

occupational health education and counseling concerning health maintenance and preventive medicine; evaluating schools, nurseries, day care centers, and other public places for environmental factors which may affect the health of military personnel or their dependents; implementing and monitoring disease and occupational illness prevention programs; conducting epidemiological investigations in support of occupational health problems and of food borne disease outbreaks; monitoring disease vector populations; providing medical surveillance over civilian and military personnel working in hazardous or potentially hazardous environments; providing inspection of substances for wholesomeness, contract compliance, storage conditions, and keeping qualities; conducting laboratory examinations of food and food contact surfaces; providing medical inspections on incoming aircraft emanating from foreign soil; and maintaining liaison and cooperation with local, state, and federal health authorities.

A2.33. FBEB – Medical Standards Management Element (PHA Cell): The Medical Standards Management Element (PHA Cell) will manage the administrative requirements for all PHAs. Aerospace/Flight Medicine will have oversight of this activity. The PHA Cell will earn 4E manpower under FAC 5318. FBEB will be used to administratively track all PHA requirements (expense and FTEs, RVUs will also be captured in this code). The CHCS location of care needs to be non-count, and primarily used for scheduling. If the PHA patient requires seeing a clinician, an appt needs to be made with the PCM and the visit count will be coded under the physician's MEPRS code. Physician time spent reviewing PHA records--without seeing the patient--can be captured here.

A2.34. FCGJ – PRP Administrative Qualifications: At bases with no active PRP mission, all PRP qualifications will occur within the Flight Medicine Clinic and coded under this code.

A2.35. FDZB - Family Member Student Travel Program: Family Member Student Travel is a program used to fund the transportation of student family members for purposes of attending school in the United States as authorized by AFI 65-601 and JFTR U5243. This account will capture travel expenses only.

A2.36. FDZC – Closing/Opening Clinical Work Centers: This code will be used to track time for personnel that are setting up or breaking down clinical services, when there is no RVU generation performed.

A2.37. FEBB - Travel for Air Force Personnel/Non-Medical Attendants: Accounts for the costs of travel for active duty Air Force personnel and their non-medical attendants assigned to locations without fixed MTF to obtain medical or dental care.

A2.38. FEBC - Travel for Family Members and Medical Attendants Overseas: Accounts for the costs of travel for the family members of active duty Air Force personnel and attendants assigned to locations without fixed MTF, when needed, to obtain medical care when stationed overseas.

A2.39. FEZA – Aero Medical Evacuation System: Accounts for all the operating expenses incurred by aero medical evacuation squadrons and detachments in support of the aero medical evacuation system. Functions may include reception and processing of air evacuation patients en-route to the MTF, as well as reception and processing of returning patients. This work center is not a bedded activity and cannot be used where there is an operational ASF.

A2.40. Family Health Initiative (FHI) Clinic Team Codes (Non-GME) 4th Level A-G & M, N, P, Q, S, U and Y: Used to report labor hours, workload and expenses for facilities using the FHI Team concept to provide primary care with Non-GME Providers.

NOTE: The Family Health Initiative is the Air Force's response to the Health Affairs Patient Centered Medical Home Concept, and you may see these terms used interchangeably.

A2.40.1. **Family Health Initiative (FHI) Clinic Team Codes (GME) 4th Level H-L:** Used to report labor hours, workload and expenses for facilities using the PCE Team concept to provide primary care with GME providers.

A2.40.2. **Trainee Health Clinics 4th Level T:** Used to report labor hours, workload and expenses for facilities with a separately organized clinic providing care to AD Trainees Only.

A2.40.3. **Deployment Health Assessments 4th Level 1 (one):** Used to report labor hours, workload and expenses for facilities with a separately organized clinic providing support deploying personnel.

A2.40.4. Ensure RC/CCs for these codes are mapped to the appropriate team, so that the expenses will be readily identifiable.

A2.40.5. Using a cost pool to help account for shared space, expenses or personnel would be advisable.

A2.40.6. **Example** – B Team: BGAB/540B – Family Health Clinic B Team, shares a supply closet with BGAC/540C-Family Health Clinic C Team, purchase those shared supplies in BGXA so that the cost of those supplies will be distributed to the teams based on the production of each of the teams.

A2.40.7. Family Health Initiative code shreds are only used in clinical areas and are only specifically used in Family Practice – BGA*. Guidance will provided if these shreds are expanded to other clinical product lines.

A2.41. 4th Level "O" Codes – Reserved.

A2.42. 4th Level "R" Codes – Reserved.

A2.43. BGAZ Family Health Clinic – Non-FHI related functions: Used to report labor hours, workload and expenses for functions not appropriately captured under the Family Health Initiative concept. These functions are but are not limited to:

A2.43.1. **Clinical Pharmacy** Used to report labor hours, workload and expenses for facilities with a separately organized clinic providing Clinical Pharmacy Services.

NOTE: This should be a clinical function performed in an ambulatory clinic, not to be tracked as DA – Pharmacy workload.

A2.43.2. **Primary Behavioral Healthcare Consultation Service:** Behavioral Health Consultation Service (BHC Service) is a term used to describe any behavioral health service operating within a primary care clinic, using a consultative model of behavioral healthcare that is being delivered by a clinically trained Behavioral Health Consultant (BHC). In general, the goal of the BHC Service is to position the Behavioral Health Consultant on the healthcare team to augment and improve the delivery of overall healthcare, including behavioral healthcare. The BHC will not be used to provide comprehensive assessment or

treatment of behavioral health conditions, as occurs in the specialty mental health clinic. The BHC may see the patient or perform limited interventions, but these activities are always designed to support the PCM's impact on the patients' health. On-going communication with the PCM regarding recommendations and the patient's status is key to the BHC's role. In contrast to specialty mental health settings, consultation by the BHC does not require a separate informed consent document since behavioral assessment and intervention are a part of the primary healthcare team's service. Moreover, documentation is recorded only in the medical record rather than in a separate mental health chart. The PCM remains in charge of the patient's care.

A2.44. BJAB – Personnel Reliability Program/Presidential Support Program (PRP/PSP): Active PRP should be booked and seen under the BJAB MEPRS code. This code is specific to PRP across the AFMS and will allow us to quantify the workload. The recent PRP manpower model resulted from a few smart people putting their craniums together and coming up with their best estimate. We, at AF/SG, want to be able to quantify the PRP workload across the AFMS in order to build a business case to take to AF/A10 requesting they fund the actual authorizations required to do PRP. It is in your best interest to keep all PRP workload within the BJAB MEPRS code.

A2.44.1. AF/SG directed that we rebuild PRP as a core competency within the AFMS. The only way we can do this is to group the PRP patients together so that they are seen by the same group of people. To this end, AF/SG directed that PRP would be managed and supervised by Flight Medicine across the AFMS.

A2.44.2. The PRP Manpower Model and the new Flight Medicine Manpower Model are linked. As we looked at the PRP population at a base, if we rounded up to get a provider under the PRP model, then we would not round up in the Flight Medicine model to earn a flight surgeon. The intent being that these PRP patients with their earned staff (FAC 5320) would be embedded / combined with Flight Medicine. Additionally, the mix of PA's and physicians in the PRP Manpower Model was determined based on available flight surgeons as preceptors.

A2.44.3. At bases that earn a stand-alone PRP clinic, the clinic (location and staff) should be integrated fully with the Flight Medicine Clinic under MEPRS code BJAB. Enroll all fly PRP patients to BJAA; workload coded as BJAB. Enroll all non-fly PRP patients to BJAB; workload coded as BJAB. The PRP-related administrative work, certifications, qualifications, etc., should be documented under MEPRS code FCGJ. The administrative work includes multi-disciplinary (Dental, Mental Health, Immunizations, Public Health, etc.) administrative evaluations.

A2.44.4. At bases that have active PRP missions, but do not earn additional PRP staff, all of these patients (flyer and non-flyer) are to be seen within the Flight Medicine Clinic under MEPRS Code BJAB. Enroll all fly and non-fly PRP patients to BJAA; workload coded as BJAB. The PRP-related administrative work, certifications, qualifications, etc., should be documented under MEPRS code FCGJ. The administrative work includes multi-disciplinary (Dental, Mental Health, Immunizations, Public Health, etc.) administrative evaluations.

Attachment 3

OFFICIAL COMMITTEE MEETINGS

Meetings to be included in FCC – EBCC Committees
Committee/Function requiring formal minutes
Aerospace Medicine Council
Cancer Function
Cost Center Manager (CCM) Meeting
Credentials Committee
Data Quality/ Information Management Working Group (DQ/IM)
Dental Executive Function
Education & Training Function
Environment of Care/Patient Safety Committee
Equipment Review Authorization Activity (ERAA)
Ethics Function
Executive Committee of the Medical Staff (ECOMS)
Executive Council
Family Advocacy Committee
Family Maltreatment Case Management Team
Health Care Council
Infection Control Committee
Medical Library Function
Medical Readiness Staff Function (MRSF)
Medical Records Function
Medical Records Review Function
Nursing Executive Function
Odyssey Board of Experts
Operative and other Invasive Procedures Function
Performance Improvement/Risk Management Function
Pharmacy & Therapeutics /Medications Management
Population Health Function
Professional Staff Function

Resuscitative Care and Special Care Function

Space Utilization Function

Tissue, Blood and Blood Components Function

NOTE: This list is not all inclusive, and several of these Committees/Functions could potentially be combined to lessen the actual Number of meetings.

Attachment 4

MEPRS SELF-INSPECTION CHECKLIST

MEPRS FILE AND TABLE MAINTENANCE REVIEW

1. **DMHRS*i* Validation**:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
A. Have the MEPRS and DMIS ID Codes on the DMHRSi Task List, CHCS/AHLTA and the EASIV ASD MEPRS Code Table been reconciled for the current Fiscal Year to ensure that both systems report the same work center/cost center by MEPRS and DMIS ID code?	Site will maintain a file copy of this reconciliation and changes so that it is available during inspections.	Annually and as changes are made throughout the year	
B. Prior to creating the final DMHRS*i* DoD EASIV*i* Create File, do the MEPRS personnel who work in the DMHRS*i* office compare and validate that there are credentialed provider man-hours reported by MEPRS and DMIS ID code in DMHRS*i*?	Site will compare DMHRS*i* EASIV Summary View Report to the CHCS Monthly Statistical Report by credentialed provider name. A file copy of this reconciliation and corrections made in DMHRS*i* should be maintained and available during inspections.	Monthly	
C. Has the Site documented changes to the DMHRS*i* Task List and filed a copy in their current DMHRS*i* Electronic FY folder which provides an audit trail of changes made each month?	Retain an electronic file copy of DMHRS*i* Task List changes to provide an audit trail so that MEPRS staff will be able to research historical information to verify when changes were made. Copy should be made available to the inspector.	As Needed	

1. **DMHRS*i* Validation**:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
D. The MEPRS Office will perform an annual review or as changes are made throughout the Fiscal Year to ensure ONLY 4th level MEPRS Codes are chargeable, and that the MEPRS/FCC in the Task Name matches the MEPRS/FCC in the Task Details?	*DMHRSi allows data entry at the 3rd level MEPRS Code which creates problems with EASIV processing. All invalid 3rd level MEPRS Codes and 4th level MEPRS Codes that have been 'End Dated' should be changed to Non (N) Chargeable by the DMHRSi MEPRS staff.*	Annually and as changes are made throughout the year	
E. Are there any MEPRS codes and/or DMIS ID combinations in DMHRS*i* that are not in the EASIV MEPRS ASD table for the current fiscal year?	Provide a printed copy of the EASIV Data Audit Report for DMHRS*i* and Include All Values; i.e., ECUs, Adjustments, etc. for the last fiscal month transmitted in the current fiscal year. Does the EASIV Data Audit Report for DMHRS*i* show FTEs and/or personnel salary imported from DMHRS*i* in a MEPRS code and or DMIS ID code that is not valid in EASIV?	As Needed	
2. EASIV/MEPRS FILE AND TABLE MAINTENANCE REVIEW:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
A. Have the MEPRS Codes and/or DMIS IDs on the EASIV MEPRS Code/ASD Table and the PEMAP Table been reconciled to each other for the current Fiscal Year?	A file copy of the reconciliation and validation of MEPRS and DMIS ID codes for the EASIV MEPRS Code/ASD Table and the PEMAP table should be available to the inspector.	Annually and as changes are made throughout the year	

2. EASIV/MEPRS FILE AND TABLE MAINTENANCE REVIEW:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
B. Is there a file copy of the EASIV ASD Table that documents changes for current Fiscal Year that were made in EASIV?	A file copy of the changes made to the EASIV MEPRS/ASD Table should be retained for audit purposes and should be available to the Inspector.	As Needed	
C. Was the current fiscal year EASIV ASD and Dataset Tables approved by AFMOA/SGAR?		Annually and as changes are made throughout the year	
D. Have the MEPRS Codes and DMIS ID codes on the CHCS MEPRS Site Definable Table and the EASIV MEPRS ASD Table been reconciled to each other for the current Fiscal Year?	Site should retain a copy of both reports to show that a comparison and validation of all MEPRS Codes and DMIS ID codes in EASIV and CHCS has been completed. Site should use a copy of the CHCS Site Definable Table Report that includes both activation and deactivation dates. File copy should be available for inspector.	Annually and as changes are made throughout the year	
E. Are there ANY MEPRS codes created in CHCS to capture and separate workload that is not on the EASIV MEPRS ASD Table?	Provide a printed copy of the EASIV Data Audit Report for CHCS workload and Include All Values; i.e., ECUs, Adjustments, etc. for the last fiscal month transmitted in the current fiscal year. Does the EASIV Data Audit Report for CHCS show workload imported from CHCS in a MEPRS code that is not valid in EASIV?	As Needed	

2. EASIV/MEPRS FILE AND TABLE MAINTENANCE REVIEW:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
F. Did the MTF MEPRS personnel complete the new FY WAM Initialization by 31 October?		Annually and as changes are made throughout the year	
G. Is there a process in place at the MTF to ensure that MEPRS codes are not created in CHCS/AHLTA without MEPRS Manager and/or AFMOA/SGAR approval?		Annually and as changes are made throughout the year	
H. Has written approval been received from AFMOA/SGAR for all MEPRS/FCCs used by the Site?		Annually and as changes are made throughout the year	
3. RECONCILIATION PROCEDURES AND MONTHLY SUSPENSE REVIEW:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
A. Is the required MEPRS Inpatient Reconciliation procedure performed every month prior to transmission of EASIV monthly data, and does all Inpatient Workload for all A MEPRS codes match in the WWR, Dataset Accepted Report, and CHCS Monthly MEPRS Activity Report?	Is a copy of Inpatient Reconciliation available with copies of WWR, EASIV Dataset Accepted Report, and CHCS Monthly Activity Report to support all inpatient workload?	Monthly	
B. Is the required MEPRS Outpatient Reconciliation procedure performed every month prior to transmission of EASIV monthly data, and does all Outpatient Workload for all B MEPRS codes match in the WWR, Datasets, and CHCS Monthly Statistical Report?	Is a copy of Outpatient Reconciliation available with copies of WWR, EASIV Dataset Accepted Report, and CHCS Monthly Statistical Report to support all outpatient workload?	Monthly	
C. Are all Ancillary/Support MEPRS codes workload in D/F accounts reconciled between MEPRS Group Reports and EASIV Datasets before the monthly EASIV transmission?	Is a copy of EASIV Dataset, MEPRS Group Reports & CHCS reconciliation available for all ancillary accounts?	Monthly	

3. RECONCILIATION PROCEDURES AND MONTHLY SUSPENSE REVIEW:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
D. Was a reconciled monthly Financial Reconciliation reviewed and signed by the MTF Resource Advisor and RMO 'prior' to transmission or retransmission of all monthly MEPRS transmissions?		Monthly	
E. Are all source reports used for financial reconciliation filed with monthly financial reconciliation?		Monthly	
F. Have all AFMOA/SGAR discrepancies/errors been corrected or validated?		Monthly	
G. Does the MTF have any outstanding anomalies on the AFMOA/SGAR MEPRS Dashboard for the areas listed below? If so, how many anomalies are unresolved?	The total number of anomalies should be noted below in Findings/Observations. The Site should provide a projected timeline per fiscal year when all outstanding AFMOA/SGAR anomalies will be corrected and retransmitted. Projected timelines for corrections and retransmissions should be noted below in Findings/Observations. Inspector should note the number of discrepancies next to each metric below.	Monthly	
H. Has the local MEPRS office resolved all outlier/variance data on MEWACS and AFMOA/SGAR Dashboard, and provided a response to AFMOA/SGAR?		Monthly	

3. RECONCILIATION PROCEDURES AND MONTHLY SUSPENSE REVIEW:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
I. Has the MEPRS office met all the published suspense dates for final monthly MEPRS transmissions? If not, please explain in Findings and Observations below.		Monthly	
4. MEPRS STAFF AND DATA QUALITY:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
A. Has a MEPRS staff member been appointed to the local Data Quality Team, and do they have an appointment letter?		Annually and as changes are made throughout the year	
B. Does the MEPRS office provide training/guidance to all work centers to improve monthly man hour reporting on a routine basis?		Annually and as changes are made throughout the year	
C. Is documentation of the DMHRS*i* training content available for review?		Annually and as changes are made throughout the year	
D. Is formal training on accurate man-hour reporting in DMHRS*i* provided at least monthly, and is documentation, such as sign-in sheets available for review?		Annually and as changes are made throughout the year	
5. MEPRS SYSTEMS ISSUES:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
A. Has the MEPRS office submitted an incident report for software problems with EASIV, DMHRS*i*, CHCS, WAM, and EASIV BOX*i* Repository?		Monthly	

5. MEPRS SYSTEMS ISSUES:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
B. Are trouble tickets and related information provided to the local DQ Manager to add to the local TMA DQ Checklist to explain any delays in MEPRS processing or other possible DQ issues in MEPRS reporting?		Monthly	
6. MEPRS PERSONNEL FEEDBACK SECTION:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
A. Are there any MTF internal problems which delay monthly DMHRS*i* processing?		Monthly	
B. Are there any MTF internal problems which delay monthly MEPRS transmissions?		Monthly	
C. Does the monthly DMHRS*i* output file contain 100% of timecards for the reporting period?	Provide discussion and/or comments for this Section in the Findings and Observations below. Provide comments on corrective action taken by MEPRS office to improve known deficiencies in Findings and Observations below.	Monthly	
D. What steps have been taken to notify local MTF leadership of work centers which have known problems with reporting accurate man-hours or workload?	Please provide a copy of the work center notification.	Monthly	

6. MEPRS PERSONNEL FEEDBACK SECTION:			
TASK	**NOTES**	**FREQUENCY**	**DATE ACCOMPLISHED**
E. Does the local MEPRS Analyst make adjustments in EASIV for misreported Contract expenses and obligations which are reported in the wrong work center by MEPRS Code?	A printed copy of the most recent EASIV Financial Audit Report should be provided to the team to provide documentation of adjustments to correct misreported contract expenses.	Monthly	
7. LINKS:			
AFMOA/SGAR/MEPRS Website: https://vc.afms.mil/AFMOA/SGA/SGAR/SGAR_MEPRS/default.aspx			
MEPRS Information Portal: http://www.meprs.info			
TRICARE Management Activity: http://tricare.mil			
RITPO Download Library: https://ritpo.satx.disa.mil/skins/ritpo/dispaly.aspx			
MHS Learn http://www.tricare.mil/tma/privacy/MilitaryHealthSystemLearningPortal.aspx			